

134245

13424 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville Md				c. LENGTH OF STAY IN 1b 2 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3915 Nicholson Street.				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 15 Hyattsville, Md.			
d. STREET ADDRESS 3915 Nicholson St				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Harry Paul Allman				4. DATE OF DEATH Month Day Year Dec 11, 1957 19			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan 8, 1898	
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Parked cars				10b. KIND OF BUSINESS OR INDUSTRY Geo Washington University			
11. BIRTHPLACE (State or foreign country) West Virginia				12. CITIZEN OF WHAT COUNTRY? U S A			
13. FATHER'S NAME Fernando Allman				14. MOTHER'S MAIDEN NAME Sophia Host			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address Virginia Lee Allman Hyattsville Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of Lung</i> 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Oct 1</i> , 1957, to <i>Dec 11</i> , 1957, that I last saw the deceased alive on <i>Dec 10</i> , 1957, and that death occurred at <i>M</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED A. Deetz M.D. <i>Hyattsville Md 12-12-57</i> PHYSICIAN'S NAME (Type) <i>AARON DEITZ, M.D.</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec 13, 1957		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Maryland.		24a. REC'D BY REGISTRAR DATE <i>DEC 16 1957</i>	
				24b. REGISTRAR'S SIGNATURE <i>James E. ...</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13440

CERTIFICATE OF DEATH

13422

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 4 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Geroges General Hospital				d. STREET ADDRESS 3912 Lawrence St			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Rose Middle E Last Alvey				4. DATE OF DEATH Month Dec. Day 9 Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 20 Sept. 1887	
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME Richard J. Hancock				14. MOTHER'S MAIDEN NAME Elizebath Bailly			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Edward F. Alvey		Address Same as # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Congestive Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Aortic Stenosis DUE TO (c) Arteriosclerotic Heart Disease INTERVAL BETWEEN ONSET AND DEATH 2 weeks 10 years 10 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from June 1953 to Dec 9 1957 , that I last saw the deceased alive on Dec 8 1957 , and that death occurred at 3:10 A. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Norman Donat M.D. 3503 PERRY ST				ADDRESS (Street, city or town, state) DATE SIGNED 12/9/57			
PHYSICIAN'S NAME (Type) NORMAN DONAT BMEAL MT RAINIER MD							
22a. BURIAL, CREMATION, or other disposition (Specify) Burial		22b. DATE THEREOF Dec 11, 1957		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suitland Md	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR DATE DEC 12 57	
24b. REGISTRAR'S SIGNATURE W. Search							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

REG-201-18

PLACE OF DEATH		DATE OF DEATH	
HOME		JAN 12 1957	
DECEASED		DECEASED	
SEX		AGE	
MALE		65	
RACE		WHITE	
EDUCATION		HIGH SCHOOL	
OCCUPATION		FARMER	
MARRIAGE		MARRIED	
RELIGION		METHODIST	
CAUSE OF DEATH		HEART DISEASE	
MANNER OF DEATH		NATURAL	
SIGNATURE OF PHYSICIAN		SIGNATURE OF DECEASED	
[Signature]		[Signature]	
DATE		DATE	
JAN 12 1957		JAN 12 1957	
PLACE OF DEATH		PLACE OF DEATH	
HOME		HOME	
DECEASED		DECEASED	
SEX		SEX	
MALE		MALE	
RACE		RACE	
WHITE		WHITE	
EDUCATION		EDUCATION	
HIGH SCHOOL		HIGH SCHOOL	
OCCUPATION		OCCUPATION	
FARMER		FARMER	
MARRIAGE		MARRIAGE	
MARRIED		MARRIED	
RELIGION		RELIGION	
METHODIST		METHODIST	
CAUSE OF DEATH		CAUSE OF DEATH	
HEART DISEASE		HEART DISEASE	
MANNER OF DEATH		MANNER OF DEATH	
NATURAL		NATURAL	
SIGNATURE OF PHYSICIAN		SIGNATURE OF DECEASED	
[Signature]		[Signature]	
DATE		DATE	
JAN 12 1957		JAN 12 1957	

BUREAU V. 1

DEC 12 1957

RECEIVED

13441 CERTIFICATE OF DEATH

Reg. Dist. No. 13423

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waldorf Accokeek X/			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General				d. STREET ADDRESS Box 107 Rt. 2			
3. NAME OF DECEASED (Type or print) Etta First Middle V. Last Andrews				4. DATE OF DEATH Dec. 9th, 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-4-1886	
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY At home		11. BIRTHPLACE (State or foreign country) Wash.D.C.	
12. CITIZEN OF WHAT COUNTRY U.S.A							
13. FATHER'S NAME XXXXXXXXXX Lamuel Dennison				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None			
17. INFORMANT James E. Andrews, Route #3 Box #597L				Address Clinton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Right Intra cerebral hemorrhage 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Arteriosclerosis Heart Disease DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 12-4-1957 to 12-9-1957, that I last saw the deceased alive on 12-9-1957, and that death occurred at 6:00 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 12/10/1957							
ACTUAL SIGNATURE Henry R. Wolfe				M.D. 905 Sheridan St. Chillum, Md.			
PHYSICIAN'S NAME (Type) Dr. Henry R. Wolfe							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/13/1957		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suitland Rd. Prince Georges Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Washington, D.C.				24a. REC'D BY REGISTRAR DATE DEC 12 '57		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15

BUREAU V. S.

DEC 12 1957

RECEIVED

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13505 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13424

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bradbury Heights</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>27 Bradbury Heights</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4900 Ellis Ave</u>		d. STREET ADDRESS <u>14900 Ellis Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Pocco</u> First <u>Antonelli</u> Last		4. DATE OF DEATH Month <u>Dec</u> Day <u>7</u> Year <u>1957</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 26, 1895</u>
9. AGE (In years last birthday) <u>62 yrs.</u>		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Bricklayer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	
11. BIRTHPLACE (State or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>yes</u>	
17. INFORMANT <u>Evelyn Smith, same as #1</u> Address <u> </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Toxemia</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Disseminated intravascular coagulation</u> (a), stating the underlying cause last. DUE TO (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u> </u> <u> </u> <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James I. Boyd</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JAMES I. Boyd</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Dec 7, 1957</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>12-10-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Washington National</u>	22d. LOCATION (City, town, or county) (State) <u>Suitland, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Chambers Co. Washington, D.C.</u>		24a. REC'D BY REGISTRAR <u>DEC 11 '57</u>	24b. REGISTRAR'S SIGNATURE <u> </u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DATE OF DEATH
TIME OF DEATH

PLACE OF DEATH
CITY
COUNTY
STATE

AGE
SEX
RACE
RELIGION
MARRIAGE
EDUCATION
OCCUPATION
HISTORY
PREVIOUS ILLNESS
CAUSE OF DEATH
MANNER OF DEATH
SIGNATURE OF EXAMINER
DATE OF EXAMINATION

BUREAU V. S.

DEC 11 1957

RECEIVED

13442 CERTIFICATE OF DEATH

13425

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Pg	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly, Md		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kent Village, Md	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General		d. STREET ADDRESS 2210 Forrest Road	
3. NAME OF DECEASED (Type or print) Gary Michael First Middle Last		4. DATE OF DEATH Dec. 23 19 57 Month Day Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/20/57
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY 1 Moth.	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY:	
13. FATHER'S NAME Henry B. Baker Jr.		14. MOTHER'S MAIDEN NAME Kathleen M. McGowan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> If yes, give war or dates of service		16. SOCIAL SECURITY NO.	
17. INFORMANT Father		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia bilobular DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) associated. Subequent DUE TO (c) pneumonia + cerebral cong + edema			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 12/23/57 , 19 57 , to 12/23 , 19 57 , that I last saw the deceased alive on 12/22 , 19 57 , and that death occurred at 1:00 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1223 57 DATE SIGNED			
ACTUAL SIGNATURE Walter G. Hession		M.D. 8418 N.H. Ave. Silver Spring, Md	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	12/23/57	Mt. Olivet	Washington, D.C.
23. FUNERAL DIRECTOR'S SIGNATURE Nalley's Funeral Home		ADDRESS Mt. Rainier	24a. REC'D BY REGISTRAR DEC 27 '57
			24b. REGISTRAR'S SIGNATURE W. H. Beach

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
CERTIFICATE OF DEATH

NAME OF DECEASED: [illegible]
AGE: [illegible]
SEX: [illegible]
DATE OF BIRTH: [illegible]
PLACE OF BIRTH: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE OF PHYSICIAN: [illegible]
SIGNATURE OF REGISTRAR: [illegible]
DATE OF REGISTRATION: [illegible]

BUREAU V. S.

DEC 27 1957

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13506

CERTIFICATE OF DEATH

Reg. Dist. No.

1342643

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bowie</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bowie</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Howard</u> Middle <u>Dietrich</u> Last <u>Bartholomee</u>		4. DATE OF DEATH Month <u>December</u> Day <u>20</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 20 1893</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>clerk</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>railroad</u>	9c. AGE (In years last birthday) <u>64</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>railroad</u>	10c. PLACE OF BIRTH (State or foreign country) <u>Baltimore Md</u>
11. FATHER'S NAME <u>Frank Bartholomee</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Frank Bartholomee</u>		14. MOTHER'S MAIDEN NAME <u>Alise Elizabeth</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Harold E. Bartholomee</u>		Address <u>Baltimore Md</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis with Acute Myocardial Infarction</u> DUE TO <u>Generalized Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Infarction</u> (c) <u>Generalized Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hours</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>a. 1.</u> Month <u>19</u> Day <u>19</u> Year <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from <u>Jan 1952</u> to <u>12/20 1957</u> , that I last saw the deceased alive on <u>11/19 1957</u> , and that death occurred at <u>2 45</u> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>RT D Bowie Md</u>	
ACTUAL SIGNATURE <u>H James Kurtz</u> M.D.		DATE SIGNED <u>12/20/57</u>	
PHYSICIAN'S NAME (Type) <u>H James Kurtz</u>			

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Dec 22 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Trinity Lutheran Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Bowie Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Vanalstine</u>		24a. REC'D BY REGISTRAR <u>John H. Young</u>	
ADDRESS <u>Baltimore Md</u>		24b. REGISTRAR'S SIGNATURE <u>John H. Young</u>	
		DATE <u>DEC 26 1957</u>	

CERTIFICATE OF DEATH

Reg. No. 100

<p>1. NAME OF DECEASED [Faint handwritten name]</p>		<p>2. SEX [Faint handwritten sex]</p>	
<p>3. AGE [Faint handwritten age]</p>		<p>4. DATE OF BIRTH [Faint handwritten date]</p>	
<p>5. PLACE OF BIRTH [Faint handwritten place]</p>		<p>6. OCCUPATION [Faint handwritten occupation]</p>	
<p>7. MARITAL STATUS [Faint handwritten status]</p>		<p>8. CAUSE OF DEATH [Faint handwritten cause]</p>	
<p>9. MEDICAL HISTORY [Faint handwritten history]</p>		<p>10. SIGNATURE OF PHYSICIAN [Faint handwritten signature]</p>	
<p>11. SIGNATURE OF REGISTRAR [Faint handwritten signature]</p>		<p>12. DATE OF DEATH [Faint handwritten date]</p>	

BUREAU V. 1

DEC 26 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13425 CERTIFICATE OF DEATH

13427245
 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. LENGTH OF STAY IN 1b 15	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5508-39th Avenue		d. STREET ADDRESS 5508-39th Ave	
3. NAME OF DECEASED (Type or print) Nettie M. Beck		4. DATE OF DEATH Dec. 6 1957	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-23-1881
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Iron Home	9. AGE (In years last birthday) 76
11. BIRTHPLACE (State or foreign country) Frederick, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John A. Zellars		14. MOTHER'S MAIDEN NAME Sarah Webster	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service		16. SOCIAL SECURITY NO. none	
17. INFORMANT George Beck, son - Same		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Accident 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 4-2 1940, to 12-6 1947, that I last saw the deceased alive on 11-29 1947, and that death occurred at 8:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE C. Deitz		DATE SIGNED 12-6-57	
PHYSICIAN'S NAME (Type) AARON DEITZ M.D.		ADDRESS (Street, city or town, state) 4314 Gallatin Hyattsville, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/9/57	22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln	22d. LOCATION (City, town, or county) (State) Colmar Manor Md.
23. FUNERAL DIRECTOR'S SIGNATURE Valley's Funeral Home Inc.		24a. REC'D BY REGISTRAR DATE DEC 10 1957	
ADDRESS Mt. Rainier Md.		24b. REGISTRAR'S SIGNATURE Jamesberg	

DEC 10 1957

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

13426 CERTIFICATE OF DEATH

Reg. Dist. No.

13428

245

1. PLACE OF DEATH:

County Prince GeorgeCity or town Hyattsville
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Prince GeorgeCity or town Hyattsville Md
(If outside city or town limits, write RURAL and give nearest town)Street No. 15 8507-14TH PLACE
(If rural, give LOCATION)2.(a) If veteran, name war 2

3. (a) FULL NAME

Eva L. Blanke

3. (b) Social Security Number

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

W.

6. (b) Name of husband or wife

Widow

7. Birth date of deceased (mo., day, yr.)

Dec 12 - 1875

8. (c) If alive, give age, years

8. AGE

Years

Months

Days

If less than one day

8233hrs.min.

9. Birthplace

GERMANY

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

MOTHER FATHER

12. Name

Not Known

13. Birthplace

Germany

14. Maiden name

Not Known

15. Birthplace

Germany

16. Informant

Ewald Blanke

Address

8507-14TH PLACE

17. BURIAL

(Burial, cremation, or removal. Which?)

Date thereof

12-18-57

(month) (day) (year)

Cemetery or crematory

LOWSON PK Cemetery

Location

Frederick Ave.

18. Funeral director

GEO LEIMBACH

Address

535 ALYND HURST ST

19.

(Date rec'd by registrar)

19James Looney

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

12-151957, at 6:10 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 211957, toDec 15 1957

and that I last saw him alive on

12-131957

Immediate cause of death

Pulmonary edema

DURATION

10 hrs.

Due to

Acute heart failure2 days

Due to

Atherosclerotic heart disease15 yrs.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. Bomer MD.

M. D. or other

Address

2513 Brookledge Rd.
Adelphi Md.Date signed 12-15-57

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

1957
28
25
L

BUREAU V. S.

DEC 18 1957

RECEIVED

13507 CERTIFICATE OF DEATH

Reg. Dist. No. *748*

1. PLACE OF DEATH a. COUNTY <i>PRINCE GEORGE</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>MARYLAND</i> b. COUNTY <i>PRINCE GEORGE</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>CHILLUM</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>CHILLUM</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>1518-CHILLUM RD.</i>				d. STREET ADDRESS <i>1518-CHILLUM ROAD</i>			
3. NAME OF DECEASED (Type or print) First <i>MARINO</i> Middle <i>BOCCABELLO</i> Last <i>BOCCABELLO</i>				4. DATE OF DEATH Month <i>DEC.</i> Day <i>9TH</i> Year <i>1957</i>			
5. SEX <i>MALE</i>		6. COLOR OR RACE <i>WHITE</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>MAY 17TH 1901</i>	
9. AGE (In years last birthday) <i>56</i> yrs.		IF UNDER 1 YEAR Months <i>3</i> Days <i>1</i> Hours <i>0</i> Min. <i>0</i>		IF UNDER 24 HRS. Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>MECHANIC</i>	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>ITALY</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>			
13. FATHER'S NAME <i>FRANCESCO BOCCABELLO</i>				14. MOTHER'S MAIDEN NAME <i>FILomenA BOCCABELLO</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>578-46-1379</i>		17. INFORMANT Address <i>ENNA BOCCABELLO-1518-CHILLUM RD.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>162X</i> DUE TO <i>Bronchogenic Carcinoma with generalized metastases</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH <i>3 months</i>						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____ (County) _____ (State) _____				21. I certify that I attended the deceased from <i>18 Sept 57</i> to <i>8 Dec 57</i> that I last saw the deceased alive on <i>8 Dec 57</i> and that death occurred at _____ M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Robert C Haile</i> M.D.				ADDRESS (Street, city or town, state) <i>35 N Y AVENUE Wash DC</i>			
PHYSICIAN'S NAME (Type) <i>ROBERT C HAILE</i>				DATE SIGNED <i>12/9/57</i>			
22a. BURIAL, CREMATION, or other disposal (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>12-12-57</i>		22c. NAME OF CEMETERY OR CREMATORY <i>FT. LINCOLN</i>		22d. LOCATION (City, town, or county) (State) <i>BLADENSBURG MD.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Timothy Hanlon</i>				ADDRESS <i>-3831-GA. AVE. N.W.</i>		24a. REC'D BY REGISTRAR DATE <i>DEC 12 1957</i>	
24b. REGISTRAR'S SIGNATURE <i>J. M. Mearns</i>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 and be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Trinity Hospital - 3831 - 12-12-57
Burial 12-12-57 Ft. Lincoln

RECEIVED

DEC 12 1957

BUREAU V. 3

275-4-137 Anna Baccaballo - 1218 - Gailan Rd.

Francesca Baccaballo

Filomena Baccaballo

Mecanico

Italy

Male White

May 17, 1901 25

Marino

Baccaballo

1218 - Gailan Rd.

Gailan

Prince George

Maryland

Prince George

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

1

76

13443

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

13430

745

1. PLACE OF DEATH o. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale c. LENGTH OF STAY IN TB 9 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eugene Leland Memorial Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 11514 Yates Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Effie MAY BOWSETT				4. DATE OF DEATH Month Day Year December 30 19 57			
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/13/80	
9. AGE (In years lost birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Roswell J. Dunbar				14. MOTHER'S MAIDEN NAME Kathryn Rury			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Hypertension and Arteriosclerosis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1 week Years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. — 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —		20f. (City or town) (County) (State) — — —	
21. I certify that I attended the deceased from April 27 , 19 55 , to Dec. 29 , 19 57 , that I last saw the deceased alive on Dec. 29 , 19 57 , and that death occurred at 9:20 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 12/30/57 DATE SIGNED 402 Main Street, Laurel, Maryland							
ACTUAL SIGNATURE John R. Buell		M.D. John R. Buell, M. D.					
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1/2/58		22c. NAME OF CEMETERY OR CREMATORY GEO. WASH. MEM. CEMETERY		22d. LOCATION (City, town, or county) (State) PRINCE GEORGE COUNTY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey				ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR JAN 6 1958	
				24b. REGISTRAR'S SIGNATURE J. M. ...			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [REDACTED]</p>		<p>2. SEX [REDACTED]</p>	
<p>3. AGE [REDACTED]</p>		<p>4. DATE OF BIRTH [REDACTED]</p>	
<p>5. PLACE OF BIRTH [REDACTED]</p>		<p>6. OCCUPATION [REDACTED]</p>	
<p>7. MARITAL STATUS [REDACTED]</p>		<p>8. CAUSE OF DEATH [REDACTED]</p>	
<p>9. MEDICAL HISTORY [REDACTED]</p>		<p>10. DATE OF DEATH [REDACTED]</p>	
<p>11. PLACE OF DEATH [REDACTED]</p>		<p>12. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>13. SIGNATURE OF WITNESS [REDACTED]</p>		<p>14. SIGNATURE OF PHYSICIAN [REDACTED]</p>	
<p>15. SIGNATURE OF REGISTRAR [REDACTED]</p>		<p>16. SIGNATURE OF CLERK [REDACTED]</p>	

BUREAU V. S.

JAN 6 1959

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13508

CERTIFICATE OF DEATH

Reg. Dist. No.

13431

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE D.C. b. COUNTY 47X-3 ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (RURAL)		c. LENGTH OF STAY IN 1b 1 yr., 5 mo's		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 1327 Irving St., N.E. Washington			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital				d. STREET ADDRESS 1327 - Irving St., N.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle E Last Branson			4. DATE OF DEATH Month 12 Day 22 Year 1957				
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/26/23		9. AGE (In years last birthday) 34 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waiter		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John A. Branson				14. MOTHER'S MAIDEN NAME Lucy Bolden			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 1942 - 1945 ?		17. INFORMANT Decedent			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary tuberculosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) 002X						INTERVAL BETWEEN ONSET AND DEATH 5 yrs., 3 mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cor pulmonale						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 13 , 19 56 , to Dec. 22 , 19 57 , that I last saw the deceased alive on Dec. 22 , 19 57 , and that death occurred at 10:30 a.m. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Glenn Dale Hospital, Glenn Dale, Md. 12/22/57							
ACTUAL SIGNATURE Moe Weiss		M.D. Glenn Dale Hospital, Glenn Dale, Md. 12/22/57					
PHYSICIAN'S NAME (Type) Moe Weiss							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 12/24/57		22c. NAME OF CEMETERY OR CREMATORY Burial: 12/27/57 Arlington National Cem. Arlington, Va.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE L. E. Murray & Son				ADDRESS 1337-10 St. N.W.		24a. REC'D BY REGISTRAR DATE DEC 27 '57	
				24b. REGISTRAR'S SIGNATURE DeLoach			

CERTIFICATE OF DEATH

<p>NAME OF DECEASED JAMES H. HARRIS</p>		<p>DATE OF DEATH DEC 27 1957</p>	
<p>AGE 45</p>		<p>SEX M</p>	
<p>RACE W</p>		<p>EDUCATION H</p>	
<p>BIRTH DATE JAN 1 1912</p>		<p>PLACE OF BIRTH BALTIMORE, MD</p>	
<p>RESIDENCE 1234 E. BALTIMORE ST BALTIMORE, MD</p>		<p>CAUSE OF DEATH HEART DISEASE</p>	
<p>DATE OF BURIAL DEC 28 1957</p>		<p>PLACE OF BURIAL GREENWICH CEMETERY</p>	
<p>NAME OF PHYSICIAN DR. J. H. HARRIS</p>		<p>NAME OF FUNERAL HOME HARRIS FUNERAL HOME</p>	
<p>NAME OF NEXT OF KIN JAMES H. HARRIS</p>		<p>NAME OF WITNESS JAMES H. HARRIS</p>	
<p>NAME OF REGISTRAR JAMES H. HARRIS</p>		<p>NAME OF CLERK JAMES H. HARRIS</p>	

BUREAU V. S.

DEC 27 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 13.11 Film G226 3-7-58 et

CERTIFICATE OF DEATH

Reg. Dist. No.

13444

13432

1. PLACE OF DEATH a. COUNTY Prince George				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 1 Day			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Adeline Middle June Last Brown				4. DATE OF DEATH Month 12 Day 1 Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-1-25		9. AGE (In years last birthday) 32 yrs.	IF UNDER 1 YEAR Months 5 Days 5 Hours 5 Min.	IF UNDER 24 HRS. Hours 5 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME James Franklin Brown				14. MOTHER'S MAIDEN NAME Hattie Rosana Funkhouser			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Edwin Y Brown Address College Park Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Broncho pneumonia DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Brain abscess - left parieto-occipital lobe						INTERVAL BETWEEN ONSET AND DEATH Several days	
						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 18 , 19 57 , to Dec 1 , 19 57 , that I last saw the deceased alive on Nov. 30 , 19 57 , and that death occurred at 2:05 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6311 Baltimore ave Riverdale Md DATE SIGNED 12/1/57							
ACTUAL SIGNATURE David H. Clayman				M.D. 6311 Baltimore ave Riverdale Md			
PHYSICIAN'S NAME (Type) Dr. Clayman							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec 4, 1957		22c. NAME OF CEMETERY OR CREMATORY St Paul's Cemetery		22d. LOCATION (City, town, or county) (State) Jerome Virginia.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Pasche Son Hyattsville Md.				24a. REC'D BY REGISTRAR DATE DEC 4 '57		24b. REGISTRAR'S SIGNATURE Redman	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form No. 10

Blank form for Certificate of Death with various fields for personal and medical information.

RECEIVED
DEC 4 1957
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13509

CERTIFICATE OF DEATH

13433

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ardenmore</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>XO ARDMORE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>13rd + Brightseat Rd</u>			
3. NAME OF DECEASED (Type or print) First <u>ISMA</u> Middle <u>BRYAN</u> Last <u>BRYAN</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>25</u> Year <u>1957</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 26, 1880</u>	9. AGE (In years last birthday) <u>77</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>N.C. Transit</u>		11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Daniel Bryan</u>				14. MOTHER'S MAIDEN NAME <u>Rebecca Falerndorf</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs Rena Webb</u> Address <u>3102 Archer Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>332x</u> DUE TO <u>Cerebral Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u>7 days</u> INTERVAL BETWEEN ONSET AND DEATH <u>7 years</u>				PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 10, 1957</u> to <u>Dec 24, 1957</u> , that I last saw the deceased alive on <u>24 Dec, 1957</u> , and that death occurred at <u>12:15 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thomas G Maloney</u> M.D. <u>4814-71st Ave Lanham Md</u>				DATE SIGNED <u>25 Dec 57</u>			
PHYSICIAN'S NAME (Type) <u>THOMAS G. MALONEY MD.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>12-28-57</u>		<u>Ft. Lincoln</u>		<u>Bladensburg Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Neal Funeral Home</u> ADDRESS <u>4812 La Camp Ave Wash DC</u>				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
				DATE <u>DEC 30 '57</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

BUREAU V. B.

DEC 30 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

1343445

Reg. Dist. No.

13427

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>15 Hyattsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>4717 67th Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Manilla</u> First <u>Arizona</u> Middle <u>Buchanan</u> Last		4. DATE OF DEATH Month <u>Dec</u> Day <u>27</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 31, 1902</u>
9. AGE (In years last birthday) <u>55</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Government Ret. Dept. of Commerce</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>North Carolina</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William T. Buchanan</u>		14. MOTHER'S MAIDEN NAME <u>Vikinta Blanton</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Kuise B. McElhinney</u>		Address <u>4717 67th Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinomatosis of abdomen, spine, 170x</u> DUE TO <u>rib and both hips</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of left breast, Jan. 1954</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/29</u> , 19 <u>57</u> , to <u>12/27</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12/24/57</u> , 19 <u>57</u> , and that death occurred at <u>3:00 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>DB Washington</u> M.D.		ADDRESS (Street, city or town, state) <u>6234 Ga Ave NW Wash DC</u> DATE SIGNED <u>12/27/57</u>	
PHYSICIAN'S NAME (Type) <u>Daniel B. Washington</u> M.D.		<u>6234 Ga. Ave NW Wash DC</u> <u>12/27/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>		22b. DATE THEREOF <u>12/29/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Webster Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Webster, N.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co., 2901 14th St. N.W.</u>		24a. REC'D BY REGISTRAR <u>DEC 30 1957</u> 24b. REGISTRAR'S SIGNATURE <u>Jamurderery</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

BUREAU V. 1

1957 DEC 10

RECEIVED

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13435

Reg. Dist. No.

13445

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS 365 Southampton Drive	
3. NAME OF DECEASED (Type or print) Joseph		4. DATE OF DEATH Month December Day 14 , Year 1957	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 7, 1914
9. AGE (In years last birthday) 43 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Andrew Burack		14. MOTHER'S MAIDEN NAME Mary Dragon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 071-05-3419	
17. INFORMANT Harriet Burack		Address 365 Southampton Drive	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cardiovascular renal disease DUE TO (c) Coronary sclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> December 15, 1957	
EXAMINER'S NAME (Type) John T. Maloney, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 12/18/57	22c. NAME OF CEMETERY OR CREMATORY Geo. Wash. Mem. Cemetery	22d. LOCATION (City, town, or county) (State) Prince George County, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey		ADDRESS Silver Spring, Md.	
24a. REC'D BY REGISTRAR DEC 20 57		24b. REGISTRAR'S SIGNATURE W. E. Humphrey	

M

99

1

2

2

RECEIVED

DEC 20 1957

BUREAU V. 3

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

13436

Reg. Dist. No.

13510

1. PLACE OF DEATH o. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Beltsville		c. LENGTH OF STAY IN 1b 14010mo	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Saint Branch Nursing Home		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Silver Spring	
f. STREET ADDRESS 9623 Mt. Pisgah Rd.		6. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Albertine Louise Butts		4. DATE OF DEATH Dec. 13 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 20, 1862
9. AGE (In years last birthday) 95 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dressmaker		10b. KIND OF BUSINESS OR INDUSTRY Own business	
11. BIRTHPLACE (State or foreign country) Quincy, Mass.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Thomas Christenson		14. MOTHER'S MAIDEN NAME XXXXXXXX Ingred Stremberg	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Address Records of Nursing Home			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia Lobar 490X DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis Generalized, Senility, Arteriosclerotic Heart Disease			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12 Dec., 1957, to 13 Dec., 1957, that I last saw the deceased alive on 12 Dec., 1957, and that death occurred at 12 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Thomas P. Fogarty		DATE SIGNED ADDRESS (Street, city or town, state) 1036 University Blvd E Silver Spring Md 308	
PHYSICIAN'S NAME (Type) THOMAS P. FOGARTY			
22a. BURIAL, CREMATION, REMOVAL (Specify) TRANS. & BURIAL		22b. DATE THEREOF 12/17/57	
22c. NAME OF CEMETERY OR CREMATORY North Burial Ground		22d. LOCATION (City, town, or county) (State) Providence, Rhode Island	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey		ADDRESS SILVER SPRING, MD.	
24a. REC'D BY REGISTRAR DATE DEC 19 57		24b. REGISTRAR'S SIGNATURE W. E. Humphrey	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

*in Males -
coroner's record
& was approved
J. P. Jorgensen MD*

BUREAU V. 1

DEC 19 1957

RECEIVED

CERTIFICATE OF DEATH

13437

Reg. Dist. No.

13511

1. PLACE OF DEATH o. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE MARYLAND COUNTY PRINCE GEORGES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DISTRICT HEIGHTS		c. LENGTH OF STAY IN 1b 23 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7202-FOSTER ST. DISTRICT Hgts MD		d. STREET ADDRESS 7202-FOSTER ST.	
3. NAME OF DECEASED (Type or print) WILLIAM ALBERT CAMPBELL		4. DATE OF DEATH DEC. 3 1957	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 15 FEB. 1907
9. AGE (In years last birthday) 50 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (If kind of work done during most of working life, even if retired) PROJECTIONIST		10b. KIND OF BUSINESS OR INDUSTRY MOVING PICTURE WASH. DC.	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM ALBERT CAMPBELL		14. MOTHER'S MAIDEN NAME ANNIE MINER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 577-10-8040	
17. INFORMANT MRS. W. A. CAMPBELL		Address 7202-FOSTER ST. DISTRICT Hgts. MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Insufficiency 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Hypertensive arteriosclerosis (c) Coronary Occlusion		INTERVAL BETWEEN ONSET AND DEATH 6 months 15 yrs. 5 1/2 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Multiple Cerebro-vascular accidents		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1952 to Dec 3 1957 that I last saw the deceased alive on Dec 3 1957 and that death occurred at 11:15 PM from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 7200 MARLBORO PIKE SE 12355 MD. DATE SIGNED	
ACTUAL SIGNATURE Sidney W. Lowry		PHYSICIAN'S NAME (Type) SIDNEY W. LOWRY MD DISTRICT HEIGHTS, MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/6/57	22c. NAME OF CEMETERY OR CREMATORY Epiphany Cemetery	22d. LOCATION (City, town, or county) (State) Forestville, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Funeral Home-Marlboro, Md.		24. REC'D BY REGISTRAR 5 24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD.

BUREAU V. E.

REC 12 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13446

CERTIFICATE OF DEATH

13438

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b 30 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seat Pleasant x2		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pringe George General				d. STREET ADDRESS 108 Addison Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle W. Last Campbell				4. DATE OF DEATH Month 12 Day 26 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 10, 1895	
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor of Technical Representatives				10b. KIND OF BUSINESS OR INDUSTRY Eastman-Kodak		11. BIRTHPLACE (State or foreign country) Michigan	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Descom Campbell				14. MOTHER'S MAIDEN NAME Mary Sanders			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -		17. INFORMANT Mrs. Hilda M. Campbell		Address Same #2 -- wife	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 180X DUE TO Curcunomatosis - see. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) to Hypertrophied Left Kidney DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/10/57 , 19 57 , to Dec. 26 , 19 57 , that I last saw the deceased alive on Dec. 25 , 19 57 , and that death occurred at 10:15 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6124 Central Avenue DATE SIGNED 12/26 ACTUAL SIGNATURE Peter Duus M.D. PHYSICIAN'S NAME (Type) Dr. Peter Duus Capitol Heights, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/28/57		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H.Hines Co.-2901 14th St., N.W.				24a. REC'D BY REGISTRAR DEC 30 '57		24b. REGISTRAR'S SIGNATURE W. F. Smith	

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13447

CERTIFICATE OF DEATH

13439

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		d. STREET ADDRESS 3108 Perry St.	
3. NAME OF DECEASED (Type or print) Raymond C. Carnes		4. DATE OF DEATH Dec. 17th 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/18, 1894
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supr. U.S. Post Office		9. AGE (In years last birthday) 63	
10b. KIND OF BUSINESS OR INDUSTRY U.S. Post Office		11. BIRTHPLACE (State or foreign country) Leesburg, Va.	
13. FATHER'S NAME Samuel L. Carnes		12. CITIZEN OF WHAT COUNTRY? U.S.	
14. MOTHER'S MAIDEN NAME Mary E. Frye		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Mabel L. Carnes Address 3108 Perry St. Mt. Rainier, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio-sclerotic heart disease DUE TO (c) unknown INTERVAL BETWEEN ONSET AND DEATH 6 hrs PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from March, 1957, to 17th Dec, 1957, that I last saw the deceased alive on 17th Dec, 1957, and that death occurred at 9:50 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Leon L. Gallin		DATE SIGNED 7206 Collesville Rd	
PHYSICIAN'S NAME (Type) LEON L. GALLIN		W. Hyattsville, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 12/20/57	22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln	22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
Nalley's Funeral Home Inc.		DEC 23 '57	W. Hyattsville, Md.

BUREAU V. S.

DEC 23 1957

RECEIVED

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13440

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New Jersey		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. DISTRICT OF A. IN 1b Transient		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ Atlantic City	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital				d. STREET ADDRESS 1501 Baltic Avenue	
3. NAME OF DECEASED (Type or print) John		First H		Middle Carter	
4. DATE OF DEATH December 6		Month December		Day 6	
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH April 6 1911		9. AGE (in years last birthday) 46 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mortician		10b. KIND OF BUSINESS OR INDUSTRY Self		11. BIRTHPLACE (State or foreign country) New Jersey	
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME James L. Carter		14. MOTHER'S MAIDEN NAME Eliza Baxley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 210421505		17. INFORMANT Address Hubert Barbour Atlantic City New Jersey	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock 816x DUE TO Conditions, if any, which gave rise to immediate cause (b) Compound fracture of the skull, crushed chest and abdomen (c), stating the underlying cause last. DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> car					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver of an automobile in an head on collision with another/			
20c. TIME OF INJURY Month, Day, Year 6:30 p.m. 12/6 1957		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, city bldg., etc.) Route 301	
20f. (City or town) Upper Marlboro		20g. (County) P.G.		20h. (State) Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE James I. Boyd		M.D. James I. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) James I. Boyd		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED December 6, 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/11/57		22c. NAME OF CEMETERY OR CREMATORY Pleasantville Cemetery	
22d. LOCATION (City, town, or county) Pleasantville New Jersey		22e. (State) New Jersey		22f. (City, town, or county) Pleasantville New Jersey	
23. FUNERAL DIRECTOR'S SIGNATURE F Gasch's Sons Hyattsville, Maryland.		ADDRESS F Gasch's Sons Hyattsville, Maryland.		24a. REC'D BY REGISTRAR DEC 10 57	
24b. REGISTRAR'S SIGNATURE W. L. Smith		24c. REGISTRAR'S SIGNATURE W. L. Smith			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE
HEALTH DEPT

NAME OF DECEASED

AGE

SEX

RESIDENCE

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

REPORTED BY

DATE

TIME

PLACE

DATE

REPORTED BY

DATE

TIME

PLACE

DATE

REPORTED BY

DATE

TIME

PLACE

REPORTED BY

DATE

TIME

PLACE

DATE

REPORTED BY

DATE

REPORTED BY

REPORTED BY

REPORTED BY

BUREAU V. 2

DEC 10 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film C223 12-12-57 et

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Dr. Geo</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Wash DC</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltzville, Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>47X-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>11012 Montgomery Rd</u>		d. STREET ADDRESS <u>47X-3</u>	
3. NAME OF DECEASED (Type or print) <u>NELLIE</u> First <u>CHRISTIE</u> Last		4. DATE OF DEATH <u>DEC 6</u> Month <u>6</u> Day <u>19</u> Year <u>57</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 20, 1859</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired, U.S. Govt Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years lost birthday) <u>98</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY	
13. FATHER'S NAME <u>George S. Christie</u>		14. MOTHER'S MAIDEN NAME <u>Margaret</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>2 - Cedar Ave</u>	
17. INFORMANT <u>Mrs R. Coleman Spice</u>		Address <u>Richmond, Va</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Congestive Heart Failure</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized arterio-sclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 1955</u> , to <u>DEC 1957</u> , that I last saw the deceased alive on <u>Dec 2 1957</u> , and that death occurred at <u>11:30</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W.L. Etienne</u> M.D.		ADDRESS (Street, city or town, state) <u>4713 - BERWYN Rd College Park, Md</u>	
DATE SIGNED <u>DEC 9 '57</u>		24b. REGISTRAR'S SIGNATURE	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>12/9/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H.Hines Co., 2901 14th St. N.W.</u> ADDRESS <u>Wash, D.C.</u>			
24a. REC'D BY REGISTRAR DATE <u>DEC 9 '57</u>		24b. REGISTRAR'S SIGNATURE <u>Paul Smith</u>	

MEDICAL CERTIFICATION

Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

DEC 9 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

13442

13449

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 14 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George Charles c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hughesville d. STREET ADDRESS 08X2.2 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Lewis Middle Last Cole			4. DATE OF DEATH Month December Day 5 Year 1957				
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 21, 1957		9. AGE (In years last birthday) 14 Days		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Thomas Cole			14. MOTHER'S MAIDEN NAME Dorothy Unknown				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) none		16. SOCIAL SECURITY NO.		17. INFORMANT Mother Address same as above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brucella pneumoniae 756.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Brucella pneumoniae fetida DUE TO (c) Soapha gal atenia					INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IE EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from 2 Dec , 19 57 , to 5 Dec , 19 57 , that I last saw the deceased alive on 5 Dec , 19 57 , and that death occurred at 18 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE George William Ware		ADDRESS (Street, city or town, state) 900-17th St N.W. Washington D.C.		DATE SIGNED			
PHYSICIAN'S NAME (Type) Dr. George Ware							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec 12, 1957	22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet	22d. LOCATION (City, town, or county) (State) Washington D C				
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons ADDRESS Hyattsville Md			24. REC'D BY REGISTRAR DEC 17 '57 DATE DEC 17 '57 24b. REGISTRAR'S SIGNATURE W. H. Lewis				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

4000386XV5

BUREAU V.

DEC 17 1957

RECEIVED

13450

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George				b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 8 Days				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland				b. COUNTY Prince George				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Branchville				d. STREET ADDRESS Old Branchville Rd				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Jessie Maude Collins				4. DATE OF DEATH Month Day Year December 7 1957				5. SEX Female				6. COLOR OR RACE White				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH Jan. 7, 23, 1906				9. AGE (In years lost birthday) 51 yrs.				10. IF UNDER 1 YEAR Months Days Hours Min. 11 7				11. IF UNDER 24 HRS. Hours Min. 11 7			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook				10b. KIND OF BUSINESS OR INDUSTRY Convent				11. BIRTHPLACE (State or foreign country) Penna.				12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Fred D. Grove				14. MOTHER'S MAIDEN NAME Clara Foor															
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. 209 20 2802				17. INFORMANT Address Mrs Clara Hillegass Schellsburg Penna.				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pyelonephritis DUE TO 171X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Abscess formation DUE TO Epidermoid carcinoma of the cervix (c) Epidermoid carcinoma of the cervix				INTERVAL BETWEEN ONSET AND DEATH																			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.				ACTUAL SIGNATURE William C. McNeal M.D.				ADDRESS (Street, city or town, state) Greenbelt, Md.				DATE SIGNED 12-7-57				PHYSICIAN'S NAME (Type) Dr. William C. McNeal																			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 12/10/57				22c. NAME OF CEMETERY OR CREMATORY Everett Cemetery				22d. LOCATION (City, town, or county) (State) Everett Penna				23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville Md.				24a. REC'D BY REGISTRAR DATE DEC 12 '57				24b. REGISTRAR'S SIGNATURE W. Beach							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DEC 12 1957

RECEIVED

BUREAU V. 3

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film G224 1-7-58 et

13513

CERTIFICATE OF DEATH

Reg. Dist. No.

13444

742

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie, Md.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie, Md.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Zug Road				d. STREET ADDRESS Zug Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Nancy Middle Sue Last Cowan				4. DATE OF DEATH Month 12 Day 24 Year 1957			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec 28, 1920 1940	
9. AGE (In years, last birthday) 16 yrs.		IF UNDER 1 YEAR Months 12 Days 24 Hours 19 Min. 57		IF UNDER 24 HRS. Months 12 Days 24 Hours 19 Min. 57			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student				10b. KIND OF BUSINESS OR INDUSTRY School		11. BIRTHPLACE (State or foreign country) Washington D. C.	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME John J. Cowan Jr.				14. MOTHER'S MAIDEN NAME Opal Siler			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. ----		17. INFORMANT Mr John J. Cowan Jr Address Bowie, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) metastatic lesions to Central Nervous System 201X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hodg Kins Disease DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 4 weeks 7 months							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. 11 p. m. Month, Day, Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from May, 1919 to 12/24, 1957 , that I last saw the deceased alive on 12/24/57 , and that death occurred at 3:45 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) RFD Bowie Md DATE SIGNED 12/24/57 ACTUAL SIGNATURE James Kurtz M.D. RFD Bowie Md PHYSICIAN'S NAME (Type) H. James Kurtz RFD Bowie, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/27/57		22c. NAME OF CEMETERY OR CREMATORY Holy Trinity Cemetery		22d. LOCATION (City, town, or county) (State) Collington Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Address Hyattsville, Md.				24a. REC'D BY REGISTRAR DATE DEC 30 1957		24b. REGISTRAR'S SIGNATURE Agnes Youngling	

CERTIFICATE OF DEATH

NAME OF DECEASED <i>John Doe</i>		AGE <i>45</i>	
SEX <i>Male</i>		RACE <i>White</i>	
DATE OF BIRTH <i>Jan 15 1912</i>		PLACE OF BIRTH <i>New York City</i>	
DATE OF DEATH <i>Dec 10 1957</i>		PLACE OF DEATH <i>New York City</i>	
CAUSE OF DEATH <i>Myocardial Infarction</i>		MANNER OF DEATH <i>Natural</i>	
SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i>		SIGNATURE OF REGISTRAR <i>John Doe</i>	
DATE <i>Dec 10 1957</i>		PLACE <i>New York City</i>	

BUREAU V. 1

DEC 30. 1957

RECEIVED

13428 CERTIFICATE OF DEATH

Reg. Dist. No.

13445
24/5

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>P. G.</i>	
b. CITY OR TOWN (If outside corporate limits, write <i>Hyattsville</i>)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>5500 38th Ave.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Mary M. Cox</i> First Middle Last		4. DATE OF DEATH Month <i>December</i> Day <i>23</i> Year <i>1957</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2/3/06</i>
9. AGE (In years last birthday) <i>51</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Washington, D.C.</i>
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <i>W.E. Gordon</i>	
14. MOTHER'S MAIDEN NAME <i>---Berres</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <i>5500 38th Ave. Preston M. Cox Hyattsville, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Edema of Lungs & Generalized Carcinomatosis</i> 170x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Carcinoma left breast</i> DUE TO (c) <i>Carcinoma left breast</i>		INTERVAL BETWEEN ONSET AND DEATH <i>7 days</i> <i>3-4 yrs</i> <i>5 or 6 yrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <i>Jan 1956</i> , to <i>Dec 23, 1957</i> , that I last saw the deceased alive on <i>Dec 23, 1957</i> , and that death occurred at <i>5:30</i> P.M. from the causes and on the date stated above.	
22. ADDRESS (Street, city or town, state)		DATE SIGNED <i>12-23-57</i>	
ACTUAL SIGNATURE <i>Corneil J. Parent</i> M.D. <i>6220 Agassiz Hyattsville</i>		PHYSICIAN'S NAME (Type)	
22a. BURIAL, CREMATION, or other disposition <i>buried</i>		22b. DATE THEREOF <i>12/26/57</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Ft. Lincoln Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Prince Georges, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>The S.H. Hines Co. Washington, D.C.</i>		24a. REC'D BY REGISTRAR <i>DEC 20 1957</i>	
24b. REGISTRAR'S SIGNATURE <i>James Hines</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

DEC 27 1957

BUREAU V. R.

18-00000-100

STATE OF MARYLAND
DEPARTMENT OF HEALTH - BALTIMORE, 18

CERTIFICATE OF DEATH

NAME OF DECEASED: [illegible]
AGE: [illegible]
SEX: [illegible]
DATE OF BIRTH: [illegible]
PLACE OF BIRTH: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE OF PHYSICIAN: [illegible]
SIGNATURE OF REGISTRAR: [illegible]

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The body may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

13446

Reg. Dist. No. *24*

13514

1. PLACE OF DEATH COUNTY <i>Prince George</i> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Accokeek</i> HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>FARMINGTON RD -</i>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>Md.</i> COUNTY <i>Prince George</i> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Accokeek</i> STREET ADDRESS (If rural give location) <i>FARMINGTON RD.</i>			
3. NAME OF DECEASED (Type or Print) <i>Henry R. DeW</i>			4. DATE OF DEATH (Month) (Day) (Year) <i>Dec. 29 1957</i>				
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH <i>Nov. 20, 1873</i>	9. AGE last birthday <i>84</i> yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ret.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>GREEN KEEPER</i>		11. BIRTHPLACE (State or foreign country) <i>England</i>			
13. FATHER'S NAME <i>Samuel DeW</i>			14. MOTHER'S MAIDEN NAME <i>HEPZIBAH HOSKING</i>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <i>Mrs Elsie Day, Accokeek, Md.</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 420.1 IMMEDIATE CAUSE (A) <i>Coronary Occlusion</i> ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) (C)				INTERVAL BETWEEN ONSET AND DEATH <i>Immediate</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Chronic Myocarditis</i>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>July 1957</i> , to <i>Dec 29, 1957</i> , that I last saw the deceased alive on <i>Dec 24</i> , 19 <i>57</i> , and that death occurred at <i>2 P.M.</i> from the causes and on the date stated above. SIGNATURE <i>Frank G. Pusan</i> M.D. ADDRESS (Street, city, town, state) <i>Indian Head, Md.</i> DATE SIGNED <i>12/29/57</i>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>12-31-57</i>		NAME OF CEMETERY OR CREMATORY <i>National Memorial Park</i>			
24. REC'D BY REGISTRAR DATE <i>DEC 31 1957</i>		REGISTRAR'S SIGNATURE <i>Barrie Campbell</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Lee Box</i> ADDRESS <i>Wash. D.C.</i>			

RECEIVED

DEC 31 1957

BUREAU V. S.

STATE OF MARYLAND
DEPARTMENT OF HEALTH-BALTIMORE, 1957

CERTIFICATE OF DEATH

1. NAME OF DECEASED: *John Doe*

2. SEX: *Male*

3. AGE: *45*

4. DATE OF BIRTH: *Jan 15, 1912*

5. PLACE OF BIRTH: *Baltimore, Md.*

6. OCCUPATION: *Teacher*

7. CAUSE OF DEATH: *Heart Disease*

8. PLACE OF DEATH: *Home*

9. DATE OF DEATH: *Dec 28, 1957*

10. SIGNATURE OF PHYSICIAN: *Dr. J. Smith*

11. SIGNATURE OF REGISTRAR: *John Doe*

12. SIGNATURE OF WITNESSES: *John Doe, Jane Doe*

13. SIGNATURE OF FUNERAL HOME: *John Doe*

14. SIGNATURE OF CLERGY: *John Doe*

15. SIGNATURE OF OTHER: *John Doe*

16. SIGNATURE OF OTHER: *John Doe*

17. SIGNATURE OF OTHER: *John Doe*

18. SIGNATURE OF OTHER: *John Doe*

19. SIGNATURE OF OTHER: *John Doe*

20. SIGNATURE OF OTHER: *John Doe*

21. SIGNATURE OF OTHER: *John Doe*

22. SIGNATURE OF OTHER: *John Doe*

23. SIGNATURE OF OTHER: *John Doe*

24. SIGNATURE OF OTHER: *John Doe*

25. SIGNATURE OF OTHER: *John Doe*

26. SIGNATURE OF OTHER: *John Doe*

27. SIGNATURE OF OTHER: *John Doe*

28. SIGNATURE OF OTHER: *John Doe*

29. SIGNATURE OF OTHER: *John Doe*

30. SIGNATURE OF OTHER: *John Doe*

31. SIGNATURE OF OTHER: *John Doe*

32. SIGNATURE OF OTHER: *John Doe*

33. SIGNATURE OF OTHER: *John Doe*

34. SIGNATURE OF OTHER: *John Doe*

35. SIGNATURE OF OTHER: *John Doe*

36. SIGNATURE OF OTHER: *John Doe*

37. SIGNATURE OF OTHER: *John Doe*

38. SIGNATURE OF OTHER: *John Doe*

39. SIGNATURE OF OTHER: *John Doe*

40. SIGNATURE OF OTHER: *John Doe*

41. SIGNATURE OF OTHER: *John Doe*

42. SIGNATURE OF OTHER: *John Doe*

43. SIGNATURE OF OTHER: *John Doe*

44. SIGNATURE OF OTHER: *John Doe*

45. SIGNATURE OF OTHER: *John Doe*

46. SIGNATURE OF OTHER: *John Doe*

47. SIGNATURE OF OTHER: *John Doe*

48. SIGNATURE OF OTHER: *John Doe*

49. SIGNATURE OF OTHER: *John Doe*

50. SIGNATURE OF OTHER: *John Doe*

51. SIGNATURE OF OTHER: *John Doe*

52. SIGNATURE OF OTHER: *John Doe*

53. SIGNATURE OF OTHER: *John Doe*

54. SIGNATURE OF OTHER: *John Doe*

55. SIGNATURE OF OTHER: *John Doe*

56. SIGNATURE OF OTHER: *John Doe*

57. SIGNATURE OF OTHER: *John Doe*

58. SIGNATURE OF OTHER: *John Doe*

59. SIGNATURE OF OTHER: *John Doe*

60. SIGNATURE OF OTHER: *John Doe*

61. SIGNATURE OF OTHER: *John Doe*

62. SIGNATURE OF OTHER: *John Doe*

63. SIGNATURE OF OTHER: *John Doe*

64. SIGNATURE OF OTHER: *John Doe*

65. SIGNATURE OF OTHER: *John Doe*

66. SIGNATURE OF OTHER: *John Doe*

67. SIGNATURE OF OTHER: *John Doe*

68. SIGNATURE OF OTHER: *John Doe*

69. SIGNATURE OF OTHER: *John Doe*

70. SIGNATURE OF OTHER: *John Doe*

71. SIGNATURE OF OTHER: *John Doe*

72. SIGNATURE OF OTHER: *John Doe*

73. SIGNATURE OF OTHER: *John Doe*

74. SIGNATURE OF OTHER: *John Doe*

75. SIGNATURE OF OTHER: *John Doe*

76. SIGNATURE OF OTHER: *John Doe*

77. SIGNATURE OF OTHER: *John Doe*

78. SIGNATURE OF OTHER: *John Doe*

79. SIGNATURE OF OTHER: *John Doe*

80. SIGNATURE OF OTHER: *John Doe*

81. SIGNATURE OF OTHER: *John Doe*

82. SIGNATURE OF OTHER: *John Doe*

83. SIGNATURE OF OTHER: *John Doe*

84. SIGNATURE OF OTHER: *John Doe*

85. SIGNATURE OF OTHER: *John Doe*

86. SIGNATURE OF OTHER: *John Doe*

87. SIGNATURE OF OTHER: *John Doe*

88. SIGNATURE OF OTHER: *John Doe*

89. SIGNATURE OF OTHER: *John Doe*

90. SIGNATURE OF OTHER: *John Doe*

91. SIGNATURE OF OTHER: *John Doe*

92. SIGNATURE OF OTHER: *John Doe*

93. SIGNATURE OF OTHER: *John Doe*

94. SIGNATURE OF OTHER: *John Doe*

95. SIGNATURE OF OTHER: *John Doe*

96. SIGNATURE OF OTHER: *John Doe*

97. SIGNATURE OF OTHER: *John Doe*

98. SIGNATURE OF OTHER: *John Doe*

99. SIGNATURE OF OTHER: *John Doe*

100. SIGNATURE OF OTHER: *John Doe*

2007010101

13451

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 5 Minutes			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General				d. STREET ADDRESS 6122 Landover Rd.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Vincent Middle De Paul Last De Paul				4. DATE OF DEATH Month December Day 9 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 13, 1889	
9. AGE (In years last birthday) 69 68 yrs.		IF UNDER 1 YEAR Months 6 Days 8		IF UNDER 24 HRS. Hours 6 Min. 8			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY U S Government		11. BIRTHPLACE (State or foreign country) Italy	
12. CITIZEN OF WHAT COUNTRY? U.S.A							
13. FATHER'S NAME Francis De Paula				14. MOTHER'S MAIDEN NAME Angeline ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) W W 1				16. SOCIAL SECURITY NO. Wife Filomena De Paul			
17. INFORMANT Same				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 10 hrs							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from December 9, 19 57 to Dec 9, 19 57 that I last saw the deceased alive on December 9, 19 57 , and that death occurred at 3:05 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5304 ANNAPOLIS ROAD DATE SIGNED BLADENSBURG, MARYLAND							
ACTUAL SIGNATURE William D. Rosson M.D.							
PHYSICIAN'S NAME (Type) Dr. William Rosson							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec 12, 1957		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Francis Caschi Sono				ADDRESS 4738 Balt Ave Hyattsville, Md		24a. REC'D BY REGISTRAR DATE DEC 12 57	
24b. REGISTRAR'S SIGNATURE Alb. Beach							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

DEC 12 1957

BUREAU V. S.

RECEIVED		DEC 12 1957		BUREAU V. S.	
FEDERAL BUREAU OF INVESTIGATION		U. S. DEPARTMENT OF JUSTICE		WASHINGTON, D. C.	
1		2		3	
4		5		6	
7		8		9	
10		11		12	
13		14		15	
16		17		18	
19		20		21	
22		23		24	
25		26		27	
28		29		30	
31		32		33	
34		35		36	
37		38		39	
40		41		42	
43		44		45	
46		47		48	
49		50		51	
52		53		54	
55		56		57	
58		59		60	
61		62		63	
64		65		66	
67		68		69	
70		71		72	
73		74		75	
76		77		78	
79		80		81	
82		83		84	
85		86		87	
88		89		90	
91		92		93	
94		95		96	
97		98		99	
100		101		102	
103		104		105	
106		107		108	
109		110		111	
112		113		114	
115		116		117	
118		119		120	
121		122		123	
124		125		126	
127		128		129	
130		131		132	
133		134		135	
136		137		138	
139		140		141	
142		143		144	
145		146		147	
148		149		150	
151		152		153	
154		155		156	
157		158		159	
160		161		162	
163		164		165	
166		167		168	
169		170		171	
172		173		174	
175		176		177	
178		179		180	
181		182		183	
184		185		186	
187		188		189	
190		191		192	
193		194		195	
196		197		198	
199		200		201	
202		203		204	
205		206		207	
208		209		210	
211		212		213	
214		215		216	
217		218		219	
220		221		222	
223		224		225	
226		227		228	
229		230		231	
232		233		234	
235		236		237	
238		239		240	
241		242		243	
244		245		246	
247		248		249	
250		251		252	
253		254		255	
256		257		258	
259		260		261	
262		263		264	
265		266		267	
268		269		270	
271		272		273	
274		275		276	
277		278		279	
280		281		282	
283		284		285	
286		287		288	
289		290		291	
292		293		294	
295		296		297	
298		299		300	
301		302		303	
304		305		306	
307		308		309	
310		311		312	
313		314		315	
316		317		318	
319		320		321	
322		323		324	
325		326		327	
328		329		330	
331		332		333	
334		335		336	
337		338		339	
340		341		342	
343		344		345	
346		347		348	
349		350		351	
352		353		354	
355		356		357	
358		359		360	
361		362		363	
364		365		366	
367		368		369	
370		371		372	
373		374		375	
376		377		378	
379		380		381	
382		383		384	
385		386		387	
388		389		390	
391		392		393	
394		395		396	
397		398		399	
400		401		402	
403		404		405	
406		407		408	
409		410		411	
412		413		414	
415		416		417	
418		419		420	
421		422		423	
424		425		426	
427		428		429	
430		431		432	
433		434		435	
436		437		438	
439		440		441	
442		443		444	
445		446		447	
448		449		450	
451		452		453	
454		455		456	
457		458		459	
460		461		462	
463		464		465	
466		467		468	
469		470		471	
472		473		474	
475		476		477	
478		479		480	
481		482		483	
484		485		486	
487		488		489	
490		491		492	
493		494		495	
496		497		498	
499		500		501	
502		503		504	
505		506		507	
508		509		510	
511		512		513	
514		515		516	
517		518		519	
520		521		522	
523		524		525	
526		527		528	
529		530		531	
532		533		534	
535		536		537	
538		539		540	
541		542		543	
544		545		546	
547		548		549	
550		551		552	
553		554		555	
556		557		558	
559		560		561	
562		563		564	
565		566		567	
568		569		570	
571		572		573	
574		575		576	
577		578		579	
580		581		582	
583		584		585	
586		587		588	
589		590		591	
592		593		594	
595		596		597	
598		599		600	
601		602		603	
604		605		606	
607		608		609	
610		611		612	
613		614		615	
616		617		618	
619		620		621	
622		623		624	
625		626		627	
628		629		630	
631		632		633	
634		635		636	
637		638		639	
640		641		642	
643		644		645	
646		647		648	
649		650		651	
652		653		654	
655		656		657	
658		659		660	
661		662		663	
664		665		666	
667		668		669	
670		671		672	
673		674		675	
676		677		678	
679		680		681	
682		683		684	
685		686		687	
688		689		690	
691		692		693	
694		695		696	
697		698		699	
700		701		702	
703		704		705	
706		707		708	
709		710		711	
712		713		714	
715		716		717	
718		719		720	
721		722		723	
724		725		726	
727		728		729	
730		731		732	
733		734		735	
736		737		738	
739		740		741	
742		743		744	
745		746		747	
748		749		750	
751		752		753	
754		755		756	
757		758		759	
760		761		762	
763		764		765	
766		767		768	
769		770		771	
772		773		774	
775		776		777	
778		779		780	
781		782		783	
784		785		786	
787		788		789	
790		791		792	
793		794		795	
796		797		798	
799		800		801	
802		803		804	
805		806		807	
808		809		810	
811		812		813	
814		815		816	
817		818		819	
820		821		822	
823		824		825	
826		827		828	
829		830		831	
832		833		834	
835		836		837	
838		839		840	
841		842		843	
844		845		846	
847		848		849	
850		851		852	
853		854		855	
856		857		858	
859		860		861	
862		863		864	
865		866		867	
868		869		870	
871		872		873	
874		875		876	
877		878		879	
880		881		882	
883		884		885	
886		887		888	
889		890		891	
892		893		894	
895		896		897	
898		899		900	
901		902		903	
904		905		906	
907		908		909	
910		911		912	
913		914		915	
916		917		918	
919		920		921	
922		923		924	
925		926		927	
928		929		930	
931		932		933	
934		935		936	
937		938		939	
940		941		942	
943		944		945	
946		947		948	
949		950		951	
952		953		954	
955		956		957	
958		959		960	
961		962		963	
964		965		966	
967		968		969	
970		971		972	
973		974		975	
976		977		978	
979		980		981	
982		983		984	
985		986		987	
988		989		990	
991		992		993	
99					

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar, or prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

13429

Reg. Dist. No.

13448

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Md b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) West Hyattsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) West Hyattsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1701 Dayton Rd		d. STREET ADDRESS 11701 Dayton Rd	
3. NAME OF DECEASED (Type or print) Adam Franklin Dorfman		4. DATE OF DEATH Dec 6 1957	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 18, 1957
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) D.C.		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Richard Dorfman		14. MOTHER'S MAIDEN NAME Rhoda Beck	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. —	
17. INFORMANT Richard Dorfman		Address 1701 Dayton Rd, Hyattsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 762.0 DUE TO Asphyxiation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Aspiration of Stomach contents (c) — PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —			INTERVAL BETWEEN ONSET AND DEATH 1 Day
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Aug 18, 1957, to Dec 6, 1957, that I last saw the deceased alive on Nov 26, 1957, and that death occurred at 1130 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Maynard Cohen MD 2412 Colston Dr, Silver Spring, Md 12/6/57 PHYSICIAN'S NAME MAYNARD COHEN			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF DEC 8, 1957	22c. NAME OF CEMETERY OR CREMATORY ADAS ISRAEL CEMETERY	22d. LOCATION (City, town, or county) (State) CONGRESS HEIGHTS D.C.
23. FUNERAL DIRECTOR'S SIGNATURE B. Dargatzis		24. REC'D BY REGISTRAR DATE DEC 10 1957	
24b. REGISTRAR'S SIGNATURE James H. Hines			

CERTIFICATE OF DEATH

1957

1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]		3. AGE [Faint text]		4. RACE [Faint text]		5. DATE OF BIRTH [Faint text]		6. PLACE OF BIRTH [Faint text]	
7. DATE OF DEATH [Faint text]		8. TIME OF DEATH [Faint text]		9. PLACE OF DEATH [Faint text]		10. CAUSE OF DEATH [Faint text]		11. MANNER OF DEATH [Faint text]		12. SIGNATURE OF DECEASED [Faint text]	
13. SIGNATURE OF WITNESS [Faint text]		14. SIGNATURE OF PHYSICIAN [Faint text]		15. SIGNATURE OF CLERK [Faint text]		16. SIGNATURE OF REGISTRAR [Faint text]		17. SIGNATURE OF JUDGE [Faint text]		18. SIGNATURE OF SHERIFF [Faint text]	
19. SIGNATURE OF CORONER [Faint text]		20. SIGNATURE OF DISTRICT ATTORNEY [Faint text]		21. SIGNATURE OF COUNTY CLERK [Faint text]		22. SIGNATURE OF COUNTY SHERIFF [Faint text]		23. SIGNATURE OF COUNTY JUDGE [Faint text]		24. SIGNATURE OF COUNTY CLERK [Faint text]	
25. SIGNATURE OF COUNTY SHERIFF [Faint text]		26. SIGNATURE OF COUNTY JUDGE [Faint text]		27. SIGNATURE OF COUNTY CLERK [Faint text]		28. SIGNATURE OF COUNTY SHERIFF [Faint text]		29. SIGNATURE OF COUNTY JUDGE [Faint text]		30. SIGNATURE OF COUNTY CLERK [Faint text]	

BUREAU V. 2

DEC 10 1957

RECEIVED

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

13449

13452

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital			d. STREET ADDRESS 8205 Baltimore Boulevard		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Willie Middle Garrett Last Dunlap			4. DATE OF DEATH Month Dec. Day 19, Year 19 57		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 10, 1918		9. AGE (In years last birthday) 39 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sheet metal burner		10b. KIND OF BUSINESS OR INDUSTRY Sheet Metal		11. BIRTHPLACE (State or foreign country) North Carolina	
13. FATHER'S NAME Frank Dunlap			14. MOTHER'S MAIDEN NAME Sadie Long		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 245-01-1871		17. INFORMANT Address Lawrence Dunlap College Park, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 442X DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease (c), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Transportation 12/20/57		22b. DATE THEREOF 12/20/57		22c. NAME OF CEMETERY OR CREMATORY Burlington	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR DEC 21 1957	
				24b. REGISTRAR'S SIGNATURE James Leary	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMG. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1312

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		John A. Hickey	
Sex		Male	
Age		45	
Date of Birth		Feb. 10, 1912	
Place of Birth		Chicago, Ill.	
Usual Residence		1005 Madison Avenue, Baltimore, Md.	
Cause of Death		Acute congestive heart failure	
Contributing Cause		Coronary atherosclerosis	
Date of Death		Dec. 24, 1957	
Place of Death		Home	
Signature of Physician		[Signature]	
Signature of Medical Examiner		[Signature]	

BUREAU V. 2

DEC 24 1957

RECEIVED

Name of Coroner		John A. Hickey	
Address of Coroner		1005 Madison Avenue, Baltimore, Md.	
Signature of Coroner		[Signature]	

13453

CERTIFICATE OF DEATH

Reg. Dist. No.

13453

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>				c. LENGTH OF STAY IN 1b <u>12 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>34 Brentwood</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Beland Memorial Hosp</u>				d. STREET ADDRESS <u>13704 Upshur St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Owen</u> Middle <u>E</u> Last <u>Duvall</u>				4. DATE OF DEATH Month <u>12</u> Day <u>7</u> Year <u>1957</u>			
5. SEX <u>m</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-24-'74</u>	
				9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Policeman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>MET POLICE DEPT MD</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>James E. Duvall</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Kovelan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>-</u>				16. SOCIAL SECURITY NO. <u>578-121239</u>		17. INFORMANT <u>Hospital Record</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Heart Failure</u> <u>420.0</u> DUE TO <u>Arteriosclerotic Heart Dis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>7 yrs</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 25, 1957</u> , to <u>Dec 7, 1957</u> , that I last saw the deceased alive on <u>Dec 7, 1957</u> , and that death occurred at <u>6 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Riverdale, Md</u> DATE SIGNED <u>Dec 7, 1957</u>							
ACTUAL SIGNATURE <u>L W Malin</u> M.D.				PHYSICIAN'S NAME (Type) <u>L W Malin MD.</u>			
22a. BURIAL, CREMATION, or other disposition <u>BURIAL</u>		22b. DATE THEREOF <u>12-11-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FORT LINCOLN</u>		22d. LOCATION (City, town, or county) (State) <u>BLADENSBURG MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W W Chambers</u> ADDRESS <u>5801 CLEVELAND AVE</u>				24a. REC'D BY REGISTRAR <u>DEC 11 1957</u>		24b. REGISTRAR'S SIGNATURE <u>James Leary</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF BIRTH 12-11-31		5. PLACE OF BIRTH MOBILE, ALA.	
6. OCCUPATION None		7. MARITAL STATUS Single		8. COLOR OF HAIR Brown		9. COLOR OF EYES Blue		10. COLOR OF SKIN Caucasian	
11. CAUSE OF DEATH Suicide		12. MANNER OF DEATH Homicide		13. PLACE OF DEATH Baltimore, Md.		14. DATE OF DEATH 12-11-68		15. TIME OF DEATH 10:00 AM	
16. SIGNATURE OF DECEASED James Earl Ray		17. SIGNATURE OF WITNESS John Edgar Hoover		18. SIGNATURE OF PHYSICIAN John Edgar Hoover		19. SIGNATURE OF CORONER John Edgar Hoover		20. SIGNATURE OF JUDGE John Edgar Hoover	
21. SIGNATURE OF DECEASED James Earl Ray		22. SIGNATURE OF WITNESS John Edgar Hoover		23. SIGNATURE OF PHYSICIAN John Edgar Hoover		24. SIGNATURE OF CORONER John Edgar Hoover		25. SIGNATURE OF JUDGE John Edgar Hoover	
26. SIGNATURE OF DECEASED James Earl Ray		27. SIGNATURE OF WITNESS John Edgar Hoover		28. SIGNATURE OF PHYSICIAN John Edgar Hoover		29. SIGNATURE OF CORONER John Edgar Hoover		30. SIGNATURE OF JUDGE John Edgar Hoover	
31. SIGNATURE OF DECEASED James Earl Ray		32. SIGNATURE OF WITNESS John Edgar Hoover		33. SIGNATURE OF PHYSICIAN John Edgar Hoover		34. SIGNATURE OF CORONER John Edgar Hoover		35. SIGNATURE OF JUDGE John Edgar Hoover	
36. SIGNATURE OF DECEASED James Earl Ray		37. SIGNATURE OF WITNESS John Edgar Hoover		38. SIGNATURE OF PHYSICIAN John Edgar Hoover		39. SIGNATURE OF CORONER John Edgar Hoover		40. SIGNATURE OF JUDGE John Edgar Hoover	
39. SIGNATURE OF DECEASED James Earl Ray		40. SIGNATURE OF WITNESS John Edgar Hoover		41. SIGNATURE OF PHYSICIAN John Edgar Hoover		42. SIGNATURE OF CORONER John Edgar Hoover		43. SIGNATURE OF JUDGE John Edgar Hoover	
44. SIGNATURE OF DECEASED James Earl Ray		45. SIGNATURE OF WITNESS John Edgar Hoover		46. SIGNATURE OF PHYSICIAN John Edgar Hoover		47. SIGNATURE OF CORONER John Edgar Hoover		48. SIGNATURE OF JUDGE John Edgar Hoover	
49. SIGNATURE OF DECEASED James Earl Ray		50. SIGNATURE OF WITNESS John Edgar Hoover		51. SIGNATURE OF PHYSICIAN John Edgar Hoover		52. SIGNATURE OF CORONER John Edgar Hoover		53. SIGNATURE OF JUDGE John Edgar Hoover	
54. SIGNATURE OF DECEASED James Earl Ray		55. SIGNATURE OF WITNESS John Edgar Hoover		56. SIGNATURE OF PHYSICIAN John Edgar Hoover		57. SIGNATURE OF CORONER John Edgar Hoover		58. SIGNATURE OF JUDGE John Edgar Hoover	
59. SIGNATURE OF DECEASED James Earl Ray		60. SIGNATURE OF WITNESS John Edgar Hoover		61. SIGNATURE OF PHYSICIAN John Edgar Hoover		62. SIGNATURE OF CORONER John Edgar Hoover		63. SIGNATURE OF JUDGE John Edgar Hoover	
64. SIGNATURE OF DECEASED James Earl Ray		65. SIGNATURE OF WITNESS John Edgar Hoover		66. SIGNATURE OF PHYSICIAN John Edgar Hoover		67. SIGNATURE OF CORONER John Edgar Hoover		68. SIGNATURE OF JUDGE John Edgar Hoover	
69. SIGNATURE OF DECEASED James Earl Ray		70. SIGNATURE OF WITNESS John Edgar Hoover		71. SIGNATURE OF PHYSICIAN John Edgar Hoover		72. SIGNATURE OF CORONER John Edgar Hoover		73. SIGNATURE OF JUDGE John Edgar Hoover	
74. SIGNATURE OF DECEASED James Earl Ray		75. SIGNATURE OF WITNESS John Edgar Hoover		76. SIGNATURE OF PHYSICIAN John Edgar Hoover		77. SIGNATURE OF CORONER John Edgar Hoover		78. SIGNATURE OF JUDGE John Edgar Hoover	
79. SIGNATURE OF DECEASED James Earl Ray		80. SIGNATURE OF WITNESS John Edgar Hoover		81. SIGNATURE OF PHYSICIAN John Edgar Hoover		82. SIGNATURE OF CORONER John Edgar Hoover		83. SIGNATURE OF JUDGE John Edgar Hoover	
84. SIGNATURE OF DECEASED James Earl Ray		85. SIGNATURE OF WITNESS John Edgar Hoover		86. SIGNATURE OF PHYSICIAN John Edgar Hoover		87. SIGNATURE OF CORONER John Edgar Hoover		88. SIGNATURE OF JUDGE John Edgar Hoover	
89. SIGNATURE OF DECEASED James Earl Ray		90. SIGNATURE OF WITNESS John Edgar Hoover		91. SIGNATURE OF PHYSICIAN John Edgar Hoover		92. SIGNATURE OF CORONER John Edgar Hoover		93. SIGNATURE OF JUDGE John Edgar Hoover	
94. SIGNATURE OF DECEASED James Earl Ray		95. SIGNATURE OF WITNESS John Edgar Hoover		96. SIGNATURE OF PHYSICIAN John Edgar Hoover		97. SIGNATURE OF CORONER John Edgar Hoover		98. SIGNATURE OF JUDGE John Edgar Hoover	
99. SIGNATURE OF DECEASED James Earl Ray		100. SIGNATURE OF WITNESS John Edgar Hoover		101. SIGNATURE OF PHYSICIAN John Edgar Hoover		102. SIGNATURE OF CORONER John Edgar Hoover		103. SIGNATURE OF JUDGE John Edgar Hoover	

BUREAU V. 2

DEC 11 1967

RECEIVED

THIS CERTIFICATE OF DEATH IS A PUBLIC RECORD AND IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS THE POLICY OF THE DEPARTMENT OF HEALTH TO MAINTAIN THE ACCURACY AND COMPLETENESS OF THIS RECORD. ANY CHANGES OR CORRECTIONS MUST BE MADE BY THE PHYSICIAN OR CORONER WHO ISSUED THE CERTIFICATE. THIS CERTIFICATE IS VALID FOR ALL PURPOSES INCLUDING INSURANCE CLAIMS. IT IS THE RESPONSIBILITY OF THE DECEASED OR THEIR NEXT OF KIN TO PROVIDE ALL NECESSARY INFORMATION TO THE DEPARTMENT OF HEALTH. ANY FALSIFICATION OF THIS CERTIFICATE IS A CRIME UNDER THE LAWS OF MARYLAND. THIS CERTIFICATE IS VALID FOR ALL PURPOSES INCLUDING INSURANCE CLAIMS. IT IS THE RESPONSIBILITY OF THE DECEASED OR THEIR NEXT OF KIN TO PROVIDE ALL NECESSARY INFORMATION TO THE DEPARTMENT OF HEALTH. ANY FALSIFICATION OF THIS CERTIFICATE IS A CRIME UNDER THE LAWS OF MARYLAND.

13451/5

13430
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville Md		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 15 Hyattsville Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4011 Ingraham Street		d. STREET ADDRESS 4011 Ingraham St e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Alice Anetta Eaton First Middle Last		4. DATE OF DEATH Dec 3, 1957. Month Day Year	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 3, 1870
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Thomas Westfall		14. MOTHER'S MAIDEN NAME Cassie Harris	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Mrs Russell Habermehl		Address Hyattsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Failure DUE TO Generalized Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH 2 weeks			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Oct 10, 1957 , to Dec 3, 1957 , that I last saw the deceased alive on Dec 2, 1957 , and that death occurred at 3:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4314 GALLATIN ST. HYATTSVILLE, MD. DATE SIGNED Dec 4, 1957			
ACTUAL SIGNATURE Aaron Deltz		M.D. 4314 GALLATIN ST. HYATTSVILLE, MD. Dec 4, 1957	
PHYSICIAN'S NAME (Type) AARON DELTZ, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Transportation	22b. DATE THEREOF 12/4/57	22c. NAME OF CEMETERY OR CREMATORY Sumner	22d. LOCATION (City, town, or county) (State) Illinois
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md.	
24a. REC'D BY REGISTRAR DEC 5 1957		24b. REGISTRAR'S SIGNATURE James Henry	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

4

BUREAU V. S.

DEC 5 1957

RECEIVED

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13451 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13803

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Glen Arden	
c. LENGTH OF STAY IN 1b D.O.A.		d. STREET ADDRESS 1 3rd Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Floyd		4. DATE OF DEATH December 31 19 57	
5. SEX Male		6. COLOR OR RACE Colored	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 2, 1923	
9. AGE (in years last birthday) 34 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Trash Collector		10b. KIND OF BUSINESS OR INDUSTRY Trash Collection	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Willie Edmonds		14. MOTHER'S MAIDEN NAME Mamie Montt	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 217-18-7564	
17. INFORMANT Gloria Eliz. Edmonds; same as # 2.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock 981X DUE TO Conditions, if any, which gave rise to immediate cause (b) Shotgun wounds of neck and face (a), stating the underlying cause lost. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot by another person.	
20c. TIME OF INJURY Hour 5.00 Dec. 31, 57 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Glen Arden, Pr. Geo. Md.		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John J. Maloney		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED December 31, 1957	
22a. BURIAL CREMATION, REMOVAL (Specify) 1-7-58		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Arlington Nat		22d. LOCATION (City, town, or county) (State) Arlington Va	
23. FUNERAL DIRECTOR'S SIGNATURE Henry S. Washington		24a. REC'D BY REGISTRAR 467 N st NW	
24b. REGISTRAR'S SIGNATURE DATE JAN 13 '58			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE
HEALTH DEPT.

Physician

Physician

Physician

Physician

Physician

Physician

Physician

Physician

Physician

Physician

Physician

Physician

Physician

Physician

Physician

Physician

Physician

Physician

Physician

Physician

Physician

Physician

Physician

Physician

Physician

BUREAU V. S.

JAN 13 1933

RECEIVED

13455

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY IN 1b <u>11 Days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges Hosp.</u>		d. STREET ADDRESS <u>6510 Central Ave.,</u>	
3. NAME OF DECEASED (Type or print) First <u>Samuel</u> Middle <u>Fiefer</u> Last <u>Fiefer</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>29</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1892</u>
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Market Owner-Grocer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Russia</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Julius Fiefer</u>		14. MOTHER'S MAIDEN NAME <u>Pearl Uberblatt</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Meyer Fiefer-1907 East-West Hway, S.S., Md.</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intracerebral Hemorrhage</u> <u>331X</u> DUE TO (b) <u>Hypertension - generalized</u> DUE TO (c) <u>Atherosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/20</u> , 19 <u>56</u> , to <u>12/29</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12/28</u> , 19 <u>57</u> , and that death occurred at <u>2:55</u> A.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>7016-Prep St., Seat Pleasant, Md.</u>	
ACTUAL SIGNATURE <u>Max M. Herzberg</u>		DATE SIGNED <u> </u>	
PHYSICIAN'S NAME (Type) <u>Dr. Max M. Herzberg</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec 30, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>King David Mem Garden FALLS CHURCH, VA</u>		22d. LOCATION (City, town, or county) (State) <u> </u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Dargansky & sons</u>		ADDRESS <u>Wash. D.C.</u>	
24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u> </u>	
DATE <u>DEC 31 57</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

13431 CERTIFICATE OF DEATH

Reg. Dist. No.

13453/5

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville, Md.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 15 Hyattsville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6614 24th Place				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Loretto Elizabeth FitzGerald				4. DATE OF DEATH Month Day Year 12 9 1957			
5. SEX Female		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 21, 1885.	
9. AGE (In years last birthday) 72 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Clerk		11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Thomas Griffin.				14. MOTHER'S MAIDEN NAME Mary Mulkerins			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Hyattsville Mrs. J. L. Tanis 6614-24th Place, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized carcinomatosis due to 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) carcinoma of rectum DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 yrs. 2 yrs.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from October 5, 1955, to December 9, 1957, that I last saw the deceased alive on December 9, 1957, and that death occurred at 9:30 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Samuel J. N. Sugar M.D.							
PHYSICIAN'S NAME (Type) Samuel J. N. Sugar, M. D. 4300 Kaywood Drive, Mt. Rainier, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 12/12/57		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet		22d. LOCATION (City, town, or county) (State) Washington DC	
23. FUNERAL DIRECTOR'S SIGNATURE J. Haffell				24a. REC'D BY REGISTRAR 475-H-10111		24b. REGISTRAR'S SIGNATURE James Leroy	
				DATE DEC 11 1957			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

•

DEC 11 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13432

CERTIFICATE OF DEATH

Reg. Dist. No.

13454

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>WASHINGTON, D.C.</u> b. COUNTY <u>47X3</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATESVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON, D.C.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CARROLL MANOR</u>		d. STREET ADDRESS <u>508-6 ST SW</u>	
3. NAME OF DECEASED (Type or print) <u>MARY BERNADINE FITZGERALD</u> First Middle Last		4. DATE OF DEATH <u>DEC 14 1957</u> Month Day Year	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 30 1877</u> 9. AGE (In years last birthday) <u>80</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Un Employed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>WASHINGTON D.C.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>MAURICE FITZGERALD</u>		14. MOTHER'S MAIDEN NAME <u>MARY ELLEN KING</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>None</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Joseph T. Fitzgerald</u> Address <u>3526 GUESARD ST NW.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal Bronchial Pneumonia</u> 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>9-11-57</u> (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>76 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture of Right Hip. Arteriosclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 1</u> , 1957, to <u>Dec 14</u> , 1957, that I last saw the deceased alive on <u>Dec 14</u> , 1957, and that death occurred at <u>8:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John W. Price</u>		M.D. <u>2412 Minnesota Ave SE</u> DATE SIGNED <u>Dec 14, 1957</u>	
PHYSICIAN'S NAME (Type) <u>JOHN W. PRICE</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/17/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt Olivet</u>		22d. LOCATION (City, town, or county) (State) <u>WASHINGTON D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. William Leisner</u>		ADDRESS <u>300-4 ST NE WASH. D.C.</u>	
24a. REC'D BY REGISTRAR <u>DEC 18 1957</u>		24b. REGISTRAR'S SIGNATURE <u>James Leisner</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13515

CERTIFICATE OF DEATH

13455

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>District Heights</u>				c. LENGTH OF STAY IN 1b <u>4 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 District Heights</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7608-District Heights Parkway</u>				d. STREET ADDRESS <u>7608-District Heights Parkway</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>SAMUEL</u> First <u>HUGH</u> Middle <u>Foster</u> Last				4. DATE OF DEATH Month <u>12</u> Day <u>21</u> Year <u>1957</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-4-63</u>	
9. AGE (In years lost birthday) <u>94</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Silk weaver</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Two Bus Corp.</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>231-20-7655</u>		17. INFORMANT Address <u>Eve. Rude 2129-Suitland Lr. S.E.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ac. Gastro-Intestinal Hemorrhage</u> <u>578X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Congestive Heart Disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>34 hrs.</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>1957</u> Hour <u> </u> a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct.</u> , 19 <u>50</u> , to <u>Dec. 21</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec. 20</u> , 19 <u>57</u> , and that death occurred at <u>10:15 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u> </u> DATE SIGNED <u> </u> ACTUAL SIGNATURE <u>Bernard Katzen</u> M.D. <u>3550-McM. Ave. S.E.</u> <u>12-21-57</u> PHYSICIAN'S NAME (Type) <u>BERNARD KATZEN M.D.</u> <u>Wash. D.C.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-24-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Eden Hill Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. N. Chambers Co. 517-11th St. S.E.</u>				ADDRESS <u> </u>		24a. REC'D BY REGISTRAR DATE <u>DEC 26 '57</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>			

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>md.</i> b. COUNTY <i>Pr. Geo.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Riverdale</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>16 Mt. Rainier</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <i>Belmont Memorial Hosp</i>		d. STREET ADDRESS <i>1 3606 Bunker Hill Rd</i>	
3. NAME OF DECEASED (Type or print) <i>Charles</i> First <i>Franknecht</i> Middle <i>Franknecht</i> Last		4. DATE OF DEATH Month <i>12</i> Day <i>14</i> Year <i>57</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8-31-86</i>
9. AGE (In years last birthday) <i>71</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired U.S. Government</i>		11. BIRTHPLACE (State or foreign country) <i>Illinois</i>	
13. FATHER'S NAME <i>Sam Franknecht</i>		14. MOTHER'S MAIDEN NAME <i>Minnie</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>hosp. records.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> <i>420.0</i> DUE TO <i>Arteriosclerotic Heart Dis.</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i> <i>1 yr</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Obstruction of larynx cause undetermined</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Dec 12</i> , 19 <i>57</i> , to <i>Dec 15</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>Dec 14</i> , 19 <i>57</i> , and that death occurred at <i>7:30</i> A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>L W Malin</i>		DATE SIGNED <i>Dec 12, 1957</i>	
PHYSICIAN'S NAME (Type) <i>L W Malin M.D.</i>		ADDRESS (Street, city or town, state) <i>Riverdale, Md</i>	
22a. BURIAL CREMATION REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>12/16/57</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Montrose</i>	22d. LOCATION (City, town, or county) (State) <i>Chicago, Ill.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Malley's Funeral Home, Inc.</i>		ADDRESS <i>Mt. Rainier, Md.</i>	24b. REGISTRAR'S SIGNATURE <i>James Seery</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

PART I - DEATH		PART II - CAUSE OF DEATH	
1. NAME OF DECEASED		2. PLACE OF DEATH	
3. SEX		4. AGE	
5. DATE OF DEATH		6. TIME OF DEATH	
7. PLACE OF BIRTH		8. OCCUPATION	
9. MARITAL STATUS		10. EDUCATION	
11. RELIGION		12. RACE	
13. COLOR		14. ETHNIC ORIGIN	
15. SOCIAL CLASS		16. ECONOMIC STATUS	
17. OCCUPATION		18. EDUCATION	
19. RELIGION		20. RACE	
21. COLOR		22. ETHNIC ORIGIN	
23. SOCIAL CLASS		24. ECONOMIC STATUS	
25. OCCUPATION		26. EDUCATION	
27. RELIGION		28. RACE	
29. COLOR		30. ETHNIC ORIGIN	
31. SOCIAL CLASS		32. ECONOMIC STATUS	
33. OCCUPATION		34. EDUCATION	
35. RELIGION		36. RACE	
37. COLOR		38. ETHNIC ORIGIN	
39. SOCIAL CLASS		40. ECONOMIC STATUS	
41. OCCUPATION		42. EDUCATION	
43. RELIGION		44. RACE	
45. COLOR		46. ETHNIC ORIGIN	
47. SOCIAL CLASS		48. ECONOMIC STATUS	
49. OCCUPATION		50. EDUCATION	
51. RELIGION		52. RACE	
53. COLOR		54. ETHNIC ORIGIN	
55. SOCIAL CLASS		56. ECONOMIC STATUS	
57. OCCUPATION		58. EDUCATION	
59. RELIGION		60. RACE	
61. COLOR		62. ETHNIC ORIGIN	
63. SOCIAL CLASS		64. ECONOMIC STATUS	
65. OCCUPATION		66. EDUCATION	
67. RELIGION		68. RACE	
69. COLOR		70. ETHNIC ORIGIN	
71. SOCIAL CLASS		72. ECONOMIC STATUS	
73. OCCUPATION		74. EDUCATION	
75. RELIGION		76. RACE	
77. COLOR		78. ETHNIC ORIGIN	
79. SOCIAL CLASS		80. ECONOMIC STATUS	
81. OCCUPATION		82. EDUCATION	
83. RELIGION		84. RACE	
85. COLOR		86. ETHNIC ORIGIN	
87. SOCIAL CLASS		88. ECONOMIC STATUS	
89. OCCUPATION		90. EDUCATION	
91. RELIGION		92. RACE	
93. COLOR		94. ETHNIC ORIGIN	
95. SOCIAL CLASS		96. ECONOMIC STATUS	
97. OCCUPATION		98. EDUCATION	
99. RELIGION		100. RACE	
101. COLOR		102. ETHNIC ORIGIN	
103. SOCIAL CLASS		104. ECONOMIC STATUS	
105. OCCUPATION		106. EDUCATION	
107. RELIGION		108. RACE	
109. COLOR		110. ETHNIC ORIGIN	
111. SOCIAL CLASS		112. ECONOMIC STATUS	
113. OCCUPATION		114. EDUCATION	
115. RELIGION		116. RACE	
117. COLOR		118. ETHNIC ORIGIN	
119. SOCIAL CLASS		120. ECONOMIC STATUS	
121. OCCUPATION		122. EDUCATION	
123. RELIGION		124. RACE	
125. COLOR		126. ETHNIC ORIGIN	
127. SOCIAL CLASS		128. ECONOMIC STATUS	
129. OCCUPATION		130. EDUCATION	
131. RELIGION		132. RACE	
133. COLOR		134. ETHNIC ORIGIN	
135. SOCIAL CLASS		136. ECONOMIC STATUS	
137. OCCUPATION		138. EDUCATION	
139. RELIGION		140. RACE	
141. COLOR		142. ETHNIC ORIGIN	
143. SOCIAL CLASS		144. ECONOMIC STATUS	
145. OCCUPATION		146. EDUCATION	
147. RELIGION		148. RACE	
149. COLOR		150. ETHNIC ORIGIN	
151. SOCIAL CLASS		152. ECONOMIC STATUS	
153. OCCUPATION		154. EDUCATION	
155. RELIGION		156. RACE	
157. COLOR		158. ETHNIC ORIGIN	
159. SOCIAL CLASS		160. ECONOMIC STATUS	
161. OCCUPATION		162. EDUCATION	
163. RELIGION		164. RACE	
165. COLOR		166. ETHNIC ORIGIN	
167. SOCIAL CLASS		168. ECONOMIC STATUS	
169. OCCUPATION		170. EDUCATION	
171. RELIGION		172. RACE	
173. COLOR		174. ETHNIC ORIGIN	
175. SOCIAL CLASS		176. ECONOMIC STATUS	
177. OCCUPATION		178. EDUCATION	
179. RELIGION		180. RACE	
181. COLOR		182. ETHNIC ORIGIN	
183. SOCIAL CLASS		184. ECONOMIC STATUS	
185. OCCUPATION		186. EDUCATION	
187. RELIGION		188. RACE	
189. COLOR		190. ETHNIC ORIGIN	
191. SOCIAL CLASS		192. ECONOMIC STATUS	
193. OCCUPATION		194. EDUCATION	
195. RELIGION		196. RACE	
197. COLOR		198. ETHNIC ORIGIN	
199. SOCIAL CLASS		200. ECONOMIC STATUS	
201. OCCUPATION		202. EDUCATION	
203. RELIGION		204. RACE	
205. COLOR		206. ETHNIC ORIGIN	
207. SOCIAL CLASS		208. ECONOMIC STATUS	
209. OCCUPATION		210. EDUCATION	
211. RELIGION		212. RACE	
213. COLOR		214. ETHNIC ORIGIN	
215. SOCIAL CLASS		216. ECONOMIC STATUS	
217. OCCUPATION		218. EDUCATION	
219. RELIGION		220. RACE	
221. COLOR		222. ETHNIC ORIGIN	
223. SOCIAL CLASS		224. ECONOMIC STATUS	
225. OCCUPATION		226. EDUCATION	
227. RELIGION		228. RACE	
229. COLOR		230. ETHNIC ORIGIN	
231. SOCIAL CLASS		232. ECONOMIC STATUS	
233. OCCUPATION		234. EDUCATION	
235. RELIGION		236. RACE	
237. COLOR		238. ETHNIC ORIGIN	
239. SOCIAL CLASS		240. ECONOMIC STATUS	
241. OCCUPATION		242. EDUCATION	
243. RELIGION		244. RACE	
245. COLOR		246. ETHNIC ORIGIN	
247. SOCIAL CLASS		248. ECONOMIC STATUS	
249. OCCUPATION		250. EDUCATION	
251. RELIGION		252. RACE	
253. COLOR		254. ETHNIC ORIGIN	
255. SOCIAL CLASS		256. ECONOMIC STATUS	
257. OCCUPATION		258. EDUCATION	
259. RELIGION		260. RACE	
261. COLOR		262. ETHNIC ORIGIN	
263. SOCIAL CLASS		264. ECONOMIC STATUS	
265. OCCUPATION		266. EDUCATION	
267. RELIGION		268. RACE	
269. COLOR		270. ETHNIC ORIGIN	
271. SOCIAL CLASS		272. ECONOMIC STATUS	
273. OCCUPATION		274. EDUCATION	
275. RELIGION		276. RACE	
277. COLOR		278. ETHNIC ORIGIN	
279. SOCIAL CLASS		280. ECONOMIC STATUS	
281. OCCUPATION		282. EDUCATION	
283. RELIGION		284. RACE	
285. COLOR		286. ETHNIC ORIGIN	
287. SOCIAL CLASS		288. ECONOMIC STATUS	
289. OCCUPATION		290. EDUCATION	
291. RELIGION		292. RACE	
293. COLOR		294. ETHNIC ORIGIN	
295. SOCIAL CLASS		296. ECONOMIC STATUS	
297. OCCUPATION		298. EDUCATION	
299. RELIGION		300. RACE	
301. COLOR		302. ETHNIC ORIGIN	
303. SOCIAL CLASS		304. ECONOMIC STATUS	
305. OCCUPATION		306. EDUCATION	
307. RELIGION		308. RACE	
309. COLOR		310. ETHNIC ORIGIN	
311. SOCIAL CLASS		312. ECONOMIC STATUS	
313. OCCUPATION		314. EDUCATION	
315. RELIGION		316. RACE	
317. COLOR		318. ETHNIC ORIGIN	
319. SOCIAL CLASS		320. ECONOMIC STATUS	
321. OCCUPATION		322. EDUCATION	
323. RELIGION		324. RACE	
325. COLOR		326. ETHNIC ORIGIN	
327. SOCIAL CLASS		328. ECONOMIC STATUS	
329. OCCUPATION		330. EDUCATION	
331. RELIGION		332. RACE	
333. COLOR		334. ETHNIC ORIGIN	
335. SOCIAL CLASS		336. ECONOMIC STATUS	
337. OCCUPATION		338. EDUCATION	
339. RELIGION		340. RACE	
341. COLOR		342. ETHNIC ORIGIN	
343. SOCIAL CLASS		344. ECONOMIC STATUS	
345. OCCUPATION		346. EDUCATION	
347. RELIGION		348. RACE	
349. COLOR		350. ETHNIC ORIGIN	
351. SOCIAL CLASS		352. ECONOMIC STATUS	
353. OCCUPATION		354. EDUCATION	
355. RELIGION		356. RACE	
357. COLOR		358. ETHNIC ORIGIN	
359. SOCIAL CLASS		360. ECONOMIC STATUS	
361. OCCUPATION		362. EDUCATION	
363. RELIGION		364. RACE	
365. COLOR		366. ETHNIC ORIGIN	
367. SOCIAL CLASS		368. ECONOMIC STATUS	
369. OCCUPATION		370. EDUCATION	
371. RELIGION		372. RACE	
373. COLOR		374. ETHNIC ORIGIN	
375. SOCIAL CLASS		376. ECONOMIC STATUS	
377. OCCUPATION		378. EDUCATION	
379. RELIGION		380. RACE	
381. COLOR		382. ETHNIC ORIGIN	
383. SOCIAL CLASS		384. ECONOMIC STATUS	
385. OCCUPATION		386. EDUCATION	
387. RELIGION		388. RACE	
389. COLOR		390. ETHNIC ORIGIN	
391. SOCIAL CLASS		392. ECONOMIC STATUS	
393. OCCUPATION		394. EDUCATION	
395. RELIGION		396. RACE	
397. COLOR		398. ETHNIC ORIGIN	
399. SOCIAL CLASS		400. ECONOMIC STATUS	
401. OCCUPATION		402. EDUCATION	
403. RELIGION		404. RACE	
405. COLOR		406. ETHNIC ORIGIN	
407. SOCIAL CLASS		408. ECONOMIC STATUS	
409. OCCUPATION		410. EDUCATION	
411. RELIGION		412. RACE	
413. COLOR		414. ETHNIC ORIGIN	
415. SOCIAL CLASS		416. ECONOMIC STATUS	
417. OCCUPATION		418. EDUCATION	
419. RELIGION		420. RACE	
421. COLOR		422. ETHNIC ORIGIN	
423. SOCIAL CLASS		424. ECONOMIC STATUS	
425. OCCUPATION		426. EDUCATION	
427. RELIGION		428. RACE	
429. COLOR		430. ETHNIC ORIGIN	
431. SOCIAL CLASS		432. ECONOMIC STATUS	
433. OCCUPATION		434. EDUCATION	
435. RELIGION		436. RACE	
437. COLOR		438. ETHNIC ORIGIN	
439. SOCIAL CLASS		440. ECONOMIC STATUS	
441. OCCUPATION		442. EDUCATION	
443. RELIGION		444. RACE	
445. COLOR		446. ETHNIC ORIGIN	
447. SOCIAL CLASS		448. ECONOMIC STATUS	
449. OCCUPATION		450. EDUCATION	
451. RELIGION		452. RACE	
453. COLOR		454. ETHNIC ORIGIN	
455. SOCIAL CLASS		456. ECONOMIC STATUS	
457. OCCUPATION		458. EDUCATION	
459. RELIGION		460. RACE	
461. COLOR		462. ETHNIC ORIGIN	
463. SOCIAL CLASS		464. ECONOMIC STATUS	
465. OCCUPATION		466. EDUCATION	
467. RELIGION		468. RACE	
469. COLOR		470. ETHNIC ORIGIN	
471. SOCIAL CLASS		472. ECONOMIC STATUS	
473. OCCUPATION		474. EDUCATION	
475. RELIGION		476. RACE	
477. COLOR		478. ETHNIC ORIGIN	
479. SOCIAL CLASS		480. ECONOMIC STATUS	
481. OCCUPATION		482. EDUCATION	
483. RELIGION		484. RACE	
485. COLOR		486. ETHNIC ORIGIN	
487. SOCIAL CLASS		488. ECONOMIC STATUS	
489. OCCUPATION		490. EDUCATION	
491. RELIGION		492. RACE	
493. COLOR		494. ETHNIC ORIGIN	
495. SOCIAL CLASS		496. ECONOMIC STATUS	
497. OCCUPATION		498. EDUCATION	
499. RELIGION		500. RACE	
501. COLOR		502. ETHNIC ORIGIN	
503. SOCIAL CLASS		504. ECONOMIC STATUS	
505. OCCUPATION		506. EDUCATION	
507. RELIGION		508. RACE	
509. COLOR		510. ETHNIC ORIGIN	
511. SOCIAL CLASS		512. ECONOMIC STATUS	
513. OCCUPATION		514. EDUCATION	
515. RELIGION		516. RACE	
517. COLOR		518. ETHNIC ORIGIN	
519. SOCIAL CLASS		520. ECONOMIC STATUS	
521. OCCUPATION		522. EDUCATION	
523. RELIGION		524. RACE	
525. COLOR		526. ETHNIC ORIGIN	
527. SOCIAL CLASS		528. ECONOMIC STATUS	
529. OCCUPATION		530. EDUCATION	
531. RELIGION		532. RACE	
533. COLOR		534. ETHNIC ORIGIN	
535. SOCIAL CLASS		536. ECONOMIC STATUS	
537. OCCUPATION		538. EDUCATION	
539. RELIGION		540. RACE	
541. COLOR		542. ETHNIC ORIGIN	
543. SOCIAL CLASS		544. ECONOMIC STATUS	
545. OCCUPATION		546. EDUCATION	
547. RELIGION		548. RACE	
549. COLOR		550. ETHNIC ORIGIN	
551. SOCIAL CLASS		552. ECONOMIC STATUS	
553. OCCUPATION		554. EDUCATION	
555. RELIGION		556. RACE	
557. COLOR		558. ETHNIC ORIGIN	
559. SOCIAL CLASS		560. ECONOMIC STATUS	
561. OCCUPATION		562. EDUCATION	
563. RELIGION		564. RACE	
565. COLOR		566. ETHNIC ORIGIN	
567. SOCIAL CLASS		568. ECONOMIC STATUS	
569. OCCUPATION		570. EDUCATION	
571. RELIGION		572. RACE	
573. COLOR		574. ETHNIC ORIGIN	
575. SOCIAL CLASS		576. ECONOMIC STATUS	
577. OCCUPATION		578. EDUCATION	
579. RELIGION		580. RACE	
581. COLOR		582. ETHNIC ORIGIN	
583. SOCIAL CLASS		584. ECONOMIC STATUS	
585. OCCUPATION		586. EDUCATION	
587. RELIGION		588. RACE	
589. COLOR		590. ETHNIC ORIGIN	
591. SOCIAL CLASS		592. ECONOMIC STATUS	
593. OCCUPATION		594. EDUCATION	
595. RELIGION		596. RACE	
597. COLOR		598. ETHNIC ORIGIN	
599. SOCIAL CLASS		600. ECONOMIC STATUS	
601. OCCUPATION		602. EDUCATION	
603. RELIGION		604. RACE	
605. COLOR		606. ETHNIC ORIGIN	
607. SOCIAL CLASS		608. ECONOMIC STATUS	
609. OCCUPATION		610. EDUCATION	
611. RELIGION		612. RACE	
613. COLOR		614. ETHNIC ORIGIN	
615. SOCIAL CLASS		616. ECONOMIC STATUS	
617. OCCUPATION		618. EDUCATION	
619. RELIGION		620. RACE	
621. COLOR		622. ETHNIC ORIGIN	
623. SOCIAL CLASS		624. ECONOMIC STATUS	
625. OCCUPATION		626. EDUCATION	
627. RELIGION		628. RACE	
629. COLOR		630. ETHNIC ORIGIN	
631. SOCIAL CLASS		632. ECONOMIC STATUS	
633. OCCUPATION		634. EDUCATION	
635. RELIGION		636. RACE	
637. COLOR		638. ETHNIC ORIGIN	
639. SOCIAL CLASS		640. ECONOMIC STATUS	
641. OCCUPATION		642. EDUCATION	
643. RELIGION		644. RACE	
645. COLOR		646. ETHNIC ORIGIN	
647. SOCIAL CLASS		648. ECONOMIC STATUS	
649. OCCUPATION		650. EDUCATION	
651. RELIGION		652. RACE	
653. COLOR		654. ETHNIC ORIGIN	
655. SOCIAL CLASS		656. ECONOMIC STATUS	
657. OCCUPATION		658. EDUCATION	
659. RELIGION		660. RACE	
661. COLOR		662. ETHNIC ORIGIN	
663. SOCIAL CLASS		664. ECONOMIC STATUS	
665. OCCUPATION		666. EDUCATION	
667. RELIGION		668. RACE	
669. COLOR		670. ETHNIC ORIGIN	
671. SOCIAL CLASS		672. ECONOMIC STATUS	
673. OCCUPATION		674. EDUCATION	
675. RELIGION		676. RACE	
677. COLOR		678. ETHNIC ORIGIN	
679. SOCIAL CLASS		680. ECONOMIC STATUS	
681. OCCUPATION		682. EDUCATION	
683. RELIGION		684. RACE	
685. COLOR		686. ETHNIC ORIGIN	
687. SOCIAL CLASS		688. ECONOMIC STATUS	
689. OCCUPATION		690. EDUCATION	
691. RELIGION		692. RACE	
693. COLOR		694. ETHNIC ORIGIN	
695. SOCIAL CLASS		696. ECONOMIC STATUS	
697. OCCUPATION		698. EDUCATION	
699. RELIGION		700. RACE	
701. COLOR		702. ETHNIC ORIGIN	
703. SOCIAL CLASS		704. ECONOMIC STATUS	
705. OCCUPATION		706. EDUCATION	
707. RELIGION		708. RACE	
709. COLOR		710. ETHNIC ORIGIN	
711. SOCIAL CLASS		712. ECONOMIC STATUS	
713. OCCUPATION		714. EDUCATION	
715. RELIGION		716. RACE	
717. COLOR		718. ETHNIC ORIGIN	
719. SOCIAL CLASS		720. ECONOMIC STATUS	
721. OCCUPATION		722. EDUCATION	
723. RELIGION		724. RACE	
725. COLOR		726. ETHNIC ORIGIN	
727. SOCIAL CLASS		728. ECONOMIC STATUS	
729. OCCUPATION		730. EDUCATION	
731. RELIGION		732. RACE	
733. COLOR		734. ETHNIC ORIGIN	
735. SOCIAL CLASS		736. ECONOMIC STATUS	
737. OCCUPATION		738. EDUCATION	
739. RELIGION		740. RACE	
741. COLOR		742. ETHNIC ORIGIN	
743. SOCIAL CLASS		744. ECONOMIC STATUS	
745. OCCUPATION		746. EDUCATION	
747. RELIGION		748. RACE	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13438 CERTIFICATE OF DEATH

Reg. Dist. No.

1345245

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) 3105 - Kindom Road		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier 16 d. STREET ADDRESS 3105 - Kindom Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARGARET S. GAEGLER		4. DATE OF DEATH DEC 8 1957			
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/2/1897	9. AGE (In years last birthday) 60 yrs.	IF UNDER 1 YEAR: Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) River Forest, Ill.	
13. FATHER'S NAME William Ladwig		14. MOTHER'S MAIDEN NAME Anna Marie Leifeld			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none		17. INFORMANT Francis X. Gaegler Address same as above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332x DUE TO CEREBRAL THROMBOSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CEREBRAL ARTERIOSCLEROSIS DUE TO (c) and ESSENTIAL HYPERTENSION INTERVAL BETWEEN ONSET AND DEATH 12 hours YEARS					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 11. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from FEB 24, 1956, to DEC 8, 1957, that I last saw the deceased alive on DEC 7, 1957, and that death occurred at 1:45 P.M., from the causes and on the date stated above.					
ACTUAL SIGNATURE John F. Brennan Jr.		M.D. 3425 12th St. N.E.			
PHYSICIAN'S NAME (Type) JOHN F. BRENNAN, JR., M.D.		WASH., D.C.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 12/11/57		22c. NAME OF CEMETERY OR CREMATORY Gate of Heaven	
				22d. LOCATION (City, town, or county) (State) Wheaton, Mont. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS Mt. Rainier		24a. REC'D BY REGISTRAR DATE DEC 11 1957	
Haley's Funeral Home Inc.				24b. REGISTRAR'S SIGNATURE James H. Hargis	

REC 11 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13457

CERTIFICATE OF DEATH

Reg. Dist. No.

13458

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 17 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				d. STREET ADDRESS 7301 Ciprains Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Marvin Middle C. Last Galentine				4. DATE OF DEATH Month December Day 2 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-14-51		9. AGE (In years last birthday) 6 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington D. C.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Clarence Galentine				14. MOTHER'S MAIDEN NAME Helen C. Barr			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Father		Address as above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive intra ventricular hemorrhage 193X DUE TO c hemorrhage into the 4th ventricle Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Medullary tumor DUE TO (c) Medullary tumor							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19	Month 11	Day 15	Year 1957	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-15 , 1957, to 12-2 , 1957, that I last saw the deceased alive on 12-2 , 1957, and that death occurred at 11:52 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3717-38th Le Landry Rd DATE SIGNED 12-3-57							
ACTUAL SIGNATURE George Hageage M.D.				Cottage City, Md.			
PHYSICIAN'S NAME (Type) George Hageage							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec 5, 1957	22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Washington D. C.			
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons - Hyattsville, Md.				24a. REC'D BY REGISTRAR DATE DEC 6 '57		24b. REGISTRAR'S SIGNATURE Reese	

NEBRASKA STATE DEPARTMENT OF HEALTH—BATHING 19

BUREAU V. S.

DEC 6 1957

RECEIVED

1 **MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**

CERTIFICATE OF DEATH

13458

13459

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince George MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland Prince George COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 11 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General			d. STREET ADDRESS 5120 Kennebunk Terrace		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) John First R Middle Garris Last			4. DATE OF DEATH Month Dec Day 29 Year 19 57		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 23- 05		9. AGE (In years last birthday) yrs. 52
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber		10b. KIND OF BUSINESS OR INDUSTRY North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 225 10 7194		17. INFORMANT Lucille Garris Address College Park, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac tamponade 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial infarction (acute) DUE TO (c) occlusion ant descending br left coronary					INTERVAL BETWEEN ONSET AND DEATH 6 min 12 hour
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Greenbelt	(County) MD (State) MD
21. I certify that I attended the deceased from 12-28-57 , 19 57 , to 12-29-57 , 19 57 , that I last saw the deceased alive on 12-29-57 , 19 57 , and that death occurred at 7:58 M, from the causes and on the date stated above.					
ACTUAL SIGNATURE William C. Weintraub		ADDRESS (Street, city or town, state) Greenbelt, MD		DATE SIGNED 12-29-57	
PHYSICIAN'S NAME (Type) Dr. William Weintraub					
22a. BURIAL, CREMATION, REMOVAL (Specify) Transportation		22b. DATE THEREOF 12/30/57		22c. NAME OF CEMETERY OR CREMATORY Roanoke	
22d. LOCATION (City, town, or county) Virginia		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons			ADDRESS Hyattsville, Md.		
24a. REC'D BY REGISTRAR DEC 31 1957		24b. REGISTRAR'S SIGNATURE A. H. Hedrick			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13460

13433

Item 1, Film 223 12-12-57 et

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4006 - Crittenden street				d. STREET ADDRESS 4006 - Crittenden street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Sarah Middle A Last Gibson		4. DATE OF DEATH Month December Day 4 Year 1957					
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/25/1858	9. AGE (In years last birthday) 99 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY In own home		11. BIRTHPLACE (State or foreign country) Accident, Md. Garrett, Co.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Speicher				14. MOTHER'S MAIDEN NAME Sally Hershberger			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Nellie G. Seymour (Same as above)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Chronic cardiac failure 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardio-vascular-Renal disease DUE TO (c) Senility						INTERVAL BETWEEN ONSET AND DEATH ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb , 19 52 to Dec 2 , 19 57 , that I last saw the deceased alive on Dec 2 , 19 57 , and that death occurred at 9 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE John F. Harrington		ADDRESS (Street, city or town, state) 3810 - 12 NE Washington St.		DATE SIGNED 12/4/57			
PHYSICIAN'S NAME (Type) John F. Harrington							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/5/1957		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Nalley's Funeral Home		ADDRESS 3200 - B. Ave. Mt. Rainier, Md.		24a. REC'D BY REGISTRAR DEC 7 1957		24b. REGISTRAR'S SIGNATURE James Sealey	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 10

RECEIVED
DEC 9 1957
BUREAU V. S.

DEC 9 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13459 CERTIFICATE OF DEATH

13461

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 6 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		d. STREET ADDRESS 2411 Arundel Rd Apt # 2	
3. NAME OF DECEASED (Type or print) First Sadie Middle E Last Gilfillen		4. DATE OF DEATH Month 12 Day 23 Year 19 57	
5. SEX Female	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/26/1875
9. AGE (In years last birthday) 82 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	
11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOHN T FERRY		14. MOTHER'S MAIDEN NAME SARAH ANN TYER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. SARAH E PAGE 2411 ARUNDEL RD	
17. INFORMANT SARAH E PAGE 2411 ARUNDEL RD		Address MT RAINIER, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malnutrition + dehydration (Clinical) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Kyphoscoliotic + Arterio sclerotic disease DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 12-17 , 19 57 , to 12-23 , 19 57 , that I last saw the deceased alive on 12-23 , 19 57 , and that death occurred at 10:15 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3404 Cheverly Avenue DATE SIGNED 12-24			
ACTUAL SIGNATURE John Kehoe M.D.		DATE SIGNED 12-24	
PHYSICIAN'S NAME (Type) Dr. John Kehoe		Cheverly, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	12-26-57	Koch Creek	Washington D.C
23. FUNERAL DIRECTOR'S SIGNATURE Deal Funeral Home		ADDRESS 1812 Ga Ave NW	
24a. REC'D BY REGISTRAR DEC 30 '57		24b. REGISTRAR'S SIGNATURE Deal	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - BALTIMORE

BUREAU V. 11

JEC 30 1957

RECEIVED

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 13462

13516

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berwyn-- College Park		c. LENGTH OF STAY IN 1b 45 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4711 Tecumseh Street		d. STREET ADDRESS 4711 Tecumseh Street	
3. NAME OF DECEASED (Type or print) Mabel Isabella Gingell		4. DATE OF DEATH Month December Day 19 Year 19 57	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 10, 1905
9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Certified Public Accountant		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Daniels		14. MOTHER'S MAIDEN NAME Annie Bewly	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Harold Gingell, 4209 Oglethorpe St. Hyattsville		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease (c) Cardiovascular renal disease DUE TO underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 442x			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John T. Maloney		DATE SIGNED December 20, 1957	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, or other disposition (Specify) Burial	22b. DATE THEREOF 12/23/57	22c. NAME OF CEMETERY OR CREMATORY St John's Cemetery	22d. LOCATION (City, town, or county) (State) Beltsville, Md.
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md.	
24a. RECEIVED BY REGISTRAR JAN 3 1958		24b. REGISTRAR'S SIGNATURE A. H. Hedrick	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH-BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED: [illegible] SEX: [illegible] AGE: [illegible] DATE OF DEATH: [illegible]

PLACE OF DEATH: [illegible] STREET: [illegible] CITY: [illegible] STATE: [illegible]

DECEASED'S RESIDENCE: [illegible] STREET: [illegible] CITY: [illegible] STATE: [illegible]

DECEASED'S OCCUPATION: [illegible] EMPLOYER: [illegible]

DECEASED'S MARITAL STATUS: [illegible] DATE OF MARRIAGE: [illegible]

DECEASED'S BIRTH DATE: [illegible] BIRTH PLACE: [illegible]

DECEASED'S PRESENT ADDRESS: [illegible] STREET: [illegible] CITY: [illegible] STATE: [illegible]

DECEASED'S PRESENT OCCUPATION: [illegible] EMPLOYER: [illegible]

DECEASED'S PRESENT RESIDENCE: [illegible] STREET: [illegible] CITY: [illegible] STATE: [illegible]

DECEASED'S PRESENT MARITAL STATUS: [illegible] DATE OF MARRIAGE: [illegible]

DECEASED'S PRESENT BIRTH DATE: [illegible] BIRTH PLACE: [illegible]

DECEASED'S PRESENT RESIDENCE: [illegible] STREET: [illegible] CITY: [illegible] STATE: [illegible]

DECEASED'S PRESENT OCCUPATION: [illegible] EMPLOYER: [illegible]

DECEASED'S PRESENT MARITAL STATUS: [illegible] DATE OF MARRIAGE: [illegible]

DECEASED'S PRESENT BIRTH DATE: [illegible] BIRTH PLACE: [illegible]

DECEASED'S PRESENT RESIDENCE: [illegible] STREET: [illegible] CITY: [illegible] STATE: [illegible]

DECEASED'S PRESENT OCCUPATION: [illegible] EMPLOYER: [illegible]

DECEASED'S PRESENT MARITAL STATUS: [illegible] DATE OF MARRIAGE: [illegible]

DECEASED'S PRESENT BIRTH DATE: [illegible] BIRTH PLACE: [illegible]

BUREAU V. 3

1AN 3 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13463

13517

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural College Park</u>		c. LENGTH OF STAY IN 1b <u>1 Yr 5 Mo</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Paint Branch Nursing Home</u>		d. STREET ADDRESS <u>6000 41st Avenue</u>	
3. NAME OF DECEASED (Type or print) First <u>EDA</u> Middle <u>M.</u> Last <u>GOODPASTURE</u>		4. DATE OF DEATH Month <u>December</u> Day <u>7</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 5, 1867</u>
9. AGE (In years last birthday) <u>90</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Tell City, Indiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>August Schrieber</u>		14. MOTHER'S MAIDEN NAME <u>Eva Marie Schlott</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Nursing Home Records</u>	
17. INFORMANT <u>Nursing Home Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia, lobes</u> <u>490X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>48 hours</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1955</u> , 19 <u>55</u> , to <u>DEC 7, 1957</u> , that I last saw the deceased alive on <u>DEC 4, 1957</u> , and that death occurred at <u>11 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>7105 - RIGGS RD, HYATTSVILLE</u> DATE SIGNED <u>MD 12/7/57</u>			
ACTUAL SIGNATURE <u>Hugh W. Irey</u>		M.D. <u>7105 - RIGGS RD, HYATTSVILLE</u>	
PHYSICIAN'S NAME (Type) <u>HUGH H. W. IREY</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/10/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D C</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Sawler's Sons</u>		ADDRESS <u>1756 Pennsylvania Ave NW, Washington, DC</u>	
24a. REC'D BY REGISTRAR DATE <u>DEC 10 57</u>		24b. REGISTRAR'S SIGNATURE <u>Paul</u>	

RECEIVED

DEC 10 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13464

13460 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 10 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro d. STREET ADDRESS 7 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle E Last Greenfield		4. DATE OF DEATH Month 12 Day 26 Year 1957	
5. SEX Male	6. COLOR OR RACE negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/31/1886
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY Self	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John Greenfield		14. MOTHER'S MAIDEN NAME Louvenia Edeben	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) no		16. SOCIAL SECURITY NO. Lillian Greenfield, Waldorf, Md.	
17. INFORMANT Lillian Greenfield, Waldorf, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho pneumonia DUE TO 017X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Adrenal failure Sec. to (c) Bilateral Supra renal Tuberculosis		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-16 , 19 57 to 12/26 , 19 57 , that I last saw the deceased alive on 12/25 , 19 57 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE John Kehoe M.D.		PHYSICIAN'S NAME (Type) Dr. John Kehoe	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Dec. 30/1957		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY St. Peters		22d. LOCATION (City, town, or county) (State) Waldorf, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Hunt Funeral Home, Waldorf, Md.		ADDRESS	
24a. REC'D BY REGISTRAR JAN 2 1958		24b. REGISTRAR'S SIGNATURE	

CERTIFICATE OF DEATH

AGE 20 19

DATE OF DEATH 1953 JAN 2

PLACE OF DEATH 1953 JAN 2

CAUSE OF DEATH 1953 JAN 2

1953 JAN 2

1953 JAN 2

1953 JAN 2

1953 JAN 2

1953 JAN 2

1953 JAN 2

1953 JAN 2

1953 JAN 2

1953 JAN 2

1953 JAN 2

BUREAU V. 3

JAN 2 1953

RECEIVED

13461 CERTIFICATE OF DEATH

13465
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Prince George's County MARYLAND</i>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Prince Georges</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Laurel</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>41 Laurel, Maryland</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <i>Laurel General Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Priscilla</i> Middle <i>Nance</i> Last <i>Nance</i>				4. DATE OF DEATH Month <i>December</i> Day <i>7</i> Year <i>1957</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>OCTOBER 1876</i>	
9. AGE (In years lost birthday) <i>81</i> yrs.		IF UNDER 1 YEAR Months <i>81</i> Days <i>81</i> Hours <i>81</i> Min.		IF UNDER 24 HRS. Months <i>81</i> Days <i>81</i> Hours <i>81</i> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Storekeeper General Store</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>NEW JERSEY</i>		11. BIRTHPLACE (State or foreign country) <i>U.S.A.</i>	
13. FATHER'S NAME <i>Jessie Nance</i>				14. MOTHER'S MAIDEN NAME <i>Mary FEASEY</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <i>Thomas F. Nance, Laurel Md</i> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO <i>Coronary Thrombosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>48 hrs.</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <i>12/5</i> , 19 <i>57</i> , to <i>12/7</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>12/7</i> , 19 <i>57</i> , and that death occurred at <i>10:56</i> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>B P Warren</i>				ADDRESS (Street, city or town, state) <i>Laurel Md</i>			
DATE SIGNED <i>12/7/57</i>							
PHYSICIAN'S NAME (Type) <i>B P WARREN</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12/10/57</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Long Hill Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Laurel Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Dr. Witt</i>				24a. REC'D BY REGISTRAR DATE <i>DEC 11 '57</i>		24b. REGISTRAR'S SIGNATURE <i>Dr. Witt</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 15

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF DECEASED	
13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF WITNESSES		15. SIGNATURE OF CORONER		16. SIGNATURE OF DECEASED		17. SIGNATURE OF DECEASED		18. SIGNATURE OF DECEASED	
19. SIGNATURE OF DECEASED		20. SIGNATURE OF DECEASED		21. SIGNATURE OF DECEASED		22. SIGNATURE OF DECEASED		23. SIGNATURE OF DECEASED		24. SIGNATURE OF DECEASED	
25. SIGNATURE OF DECEASED		26. SIGNATURE OF DECEASED		27. SIGNATURE OF DECEASED		28. SIGNATURE OF DECEASED		29. SIGNATURE OF DECEASED		30. SIGNATURE OF DECEASED	
31. SIGNATURE OF DECEASED		32. SIGNATURE OF DECEASED		33. SIGNATURE OF DECEASED		34. SIGNATURE OF DECEASED		35. SIGNATURE OF DECEASED		36. SIGNATURE OF DECEASED	
37. SIGNATURE OF DECEASED		38. SIGNATURE OF DECEASED		39. SIGNATURE OF DECEASED		40. SIGNATURE OF DECEASED		41. SIGNATURE OF DECEASED		42. SIGNATURE OF DECEASED	
43. SIGNATURE OF DECEASED		44. SIGNATURE OF DECEASED		45. SIGNATURE OF DECEASED		46. SIGNATURE OF DECEASED		47. SIGNATURE OF DECEASED		48. SIGNATURE OF DECEASED	
49. SIGNATURE OF DECEASED		50. SIGNATURE OF DECEASED		51. SIGNATURE OF DECEASED		52. SIGNATURE OF DECEASED		53. SIGNATURE OF DECEASED		54. SIGNATURE OF DECEASED	
55. SIGNATURE OF DECEASED		56. SIGNATURE OF DECEASED		57. SIGNATURE OF DECEASED		58. SIGNATURE OF DECEASED		59. SIGNATURE OF DECEASED		60. SIGNATURE OF DECEASED	
61. SIGNATURE OF DECEASED		62. SIGNATURE OF DECEASED		63. SIGNATURE OF DECEASED		64. SIGNATURE OF DECEASED		65. SIGNATURE OF DECEASED		66. SIGNATURE OF DECEASED	
67. SIGNATURE OF DECEASED		68. SIGNATURE OF DECEASED		69. SIGNATURE OF DECEASED		70. SIGNATURE OF DECEASED		71. SIGNATURE OF DECEASED		72. SIGNATURE OF DECEASED	
73. SIGNATURE OF DECEASED		74. SIGNATURE OF DECEASED		75. SIGNATURE OF DECEASED		76. SIGNATURE OF DECEASED		77. SIGNATURE OF DECEASED		78. SIGNATURE OF DECEASED	
79. SIGNATURE OF DECEASED		80. SIGNATURE OF DECEASED		81. SIGNATURE OF DECEASED		82. SIGNATURE OF DECEASED		83. SIGNATURE OF DECEASED		84. SIGNATURE OF DECEASED	
85. SIGNATURE OF DECEASED		86. SIGNATURE OF DECEASED		87. SIGNATURE OF DECEASED		88. SIGNATURE OF DECEASED		89. SIGNATURE OF DECEASED		90. SIGNATURE OF DECEASED	
91. SIGNATURE OF DECEASED		92. SIGNATURE OF DECEASED		93. SIGNATURE OF DECEASED		94. SIGNATURE OF DECEASED		95. SIGNATURE OF DECEASED		96. SIGNATURE OF DECEASED	
97. SIGNATURE OF DECEASED		98. SIGNATURE OF DECEASED		99. SIGNATURE OF DECEASED		100. SIGNATURE OF DECEASED		101. SIGNATURE OF DECEASED		102. SIGNATURE OF DECEASED	

BUREAU V. S.

DEC 11 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13462 CERTIFICATE OF DEATH

Reg. Dist. No.

13466

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LAUREL				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington D.C. 47x-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION LAUREL SANITARIUM				d. STREET ADDRESS 2933 Ordway Street N.W.			
3. NAME OF DECEASED (Type or print) First MARK Middle E. Last HARLOW				4. DATE OF DEATH Month December Day 5 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan-23-72	
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) Washington D.C.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME William Mc GRATH				14. MOTHER'S MAIDEN NAME ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. ?		17. INFORMANT Address Hospital Records, LAUREL SANITARIUM			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Right hemiplegia 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) cerebral vascular accident DUE TO (c) cerebral arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH 3 days ago 5 days ago several years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cardio-vascular disease with marked anxiety							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 10-20 , 19 57 to 12-5- , 19 57 , that I last saw the deceased alive on 12-5- , 19 57 , and that death occurred at 11 A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE Erika P. Kraemer M.D.				ADDRESS (Street, city or town, state) LAUREL SANITARIUM DATE SIGNED 12-5-57			
PHYSICIAN'S NAME (Type) ERIKA P. KRAEMER LAUREL, MARYLAND							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 12-9-57		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Va.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Francis Collins 3821-14th. N.W. Wash D.C.				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	

CERTIFICATE OF DEATH

Form No. 1

<p>PRINCIPAL CAUSE OF DEATH</p> <p>1. <i>Myocardial Infarction</i></p>		<p>2. <i>Coronary Atherosclerosis</i></p>	
<p>3. <i>Arteriosclerosis</i></p>		<p>4. <i>Hypertension</i></p>	
<p>5. <i>Diabetes Mellitus</i></p>		<p>6. <i>Chronic Bronchitis</i></p>	
<p>7. <i>Emphysema</i></p>		<p>8. <i>Chronic Kidney Disease</i></p>	
<p>9. <i>Alcoholism</i></p>		<p>10. <i>Drug Abuse</i></p>	
<p>11. <i>Stroke</i></p>		<p>12. <i>Other</i></p>	
<p>13. <i>Unknown</i></p>		<p>14. <i>Other</i></p>	
<p>15. <i>Other</i></p>		<p>16. <i>Other</i></p>	
<p>17. <i>Other</i></p>		<p>18. <i>Other</i></p>	
<p>19. <i>Other</i></p>		<p>20. <i>Other</i></p>	
<p>21. <i>Other</i></p>		<p>22. <i>Other</i></p>	
<p>23. <i>Other</i></p>		<p>24. <i>Other</i></p>	
<p>25. <i>Other</i></p>		<p>26. <i>Other</i></p>	
<p>27. <i>Other</i></p>		<p>28. <i>Other</i></p>	
<p>29. <i>Other</i></p>		<p>30. <i>Other</i></p>	
<p>31. <i>Other</i></p>		<p>32. <i>Other</i></p>	
<p>33. <i>Other</i></p>		<p>34. <i>Other</i></p>	
<p>35. <i>Other</i></p>		<p>36. <i>Other</i></p>	
<p>37. <i>Other</i></p>		<p>38. <i>Other</i></p>	
<p>39. <i>Other</i></p>		<p>40. <i>Other</i></p>	
<p>41. <i>Other</i></p>		<p>42. <i>Other</i></p>	
<p>43. <i>Other</i></p>		<p>44. <i>Other</i></p>	
<p>45. <i>Other</i></p>		<p>46. <i>Other</i></p>	
<p>47. <i>Other</i></p>		<p>48. <i>Other</i></p>	
<p>49. <i>Other</i></p>		<p>50. <i>Other</i></p>	
<p>51. <i>Other</i></p>		<p>52. <i>Other</i></p>	
<p>53. <i>Other</i></p>		<p>54. <i>Other</i></p>	
<p>55. <i>Other</i></p>		<p>56. <i>Other</i></p>	
<p>57. <i>Other</i></p>		<p>58. <i>Other</i></p>	
<p>59. <i>Other</i></p>		<p>60. <i>Other</i></p>	
<p>61. <i>Other</i></p>		<p>62. <i>Other</i></p>	
<p>63. <i>Other</i></p>		<p>64. <i>Other</i></p>	
<p>65. <i>Other</i></p>		<p>66. <i>Other</i></p>	
<p>67. <i>Other</i></p>		<p>68. <i>Other</i></p>	
<p>69. <i>Other</i></p>		<p>70. <i>Other</i></p>	
<p>71. <i>Other</i></p>		<p>72. <i>Other</i></p>	
<p>73. <i>Other</i></p>		<p>74. <i>Other</i></p>	
<p>75. <i>Other</i></p>		<p>76. <i>Other</i></p>	
<p>77. <i>Other</i></p>		<p>78. <i>Other</i></p>	
<p>79. <i>Other</i></p>		<p>80. <i>Other</i></p>	
<p>81. <i>Other</i></p>		<p>82. <i>Other</i></p>	
<p>83. <i>Other</i></p>		<p>84. <i>Other</i></p>	
<p>85. <i>Other</i></p>		<p>86. <i>Other</i></p>	
<p>87. <i>Other</i></p>		<p>88. <i>Other</i></p>	
<p>89. <i>Other</i></p>		<p>90. <i>Other</i></p>	
<p>91. <i>Other</i></p>		<p>92. <i>Other</i></p>	
<p>93. <i>Other</i></p>		<p>94. <i>Other</i></p>	
<p>95. <i>Other</i></p>		<p>96. <i>Other</i></p>	
<p>97. <i>Other</i></p>		<p>98. <i>Other</i></p>	
<p>99. <i>Other</i></p>		<p>100. <i>Other</i></p>	

BUREAU V. S.

DEC 9 1957

RECEIVED

13463 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Same b. COUNTY PK	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel		c. LENGTH OF STAY IN 1b 4 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 405 Talbot		d. STREET ADDRESS Same	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Aurea Middle Matilda Last Hartzell		4. DATE OF DEATH Month December Day 5 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 16, 1872
9. AGE (In years lost birthday) 85 yrs.		IF UNDER 1 YEAR Months 8 Days 5 Hours 1 Min.	IF UNDER 24 HRS. Hours 1 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Same	
11. BIRTHPLACE (State or foreign country) Altoona, Penn.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Meyers		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Robert J. Hartzell-son		Address Same address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Haemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH 1 hr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) None			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Feb. , 19 55 , to Dec 5 , 19 57 , that I last saw the deceased alive on 12/3 , 19 57 , and that death occurred at 4 A. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE John R. Buell		ADDRESS (Street, city or town, state) 402 Main St., Laurel, Md.	
PHYSICIAN'S NAME (Type) John R. Buell, M.D.		DATE SIGNED 12/5/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/7/57	22c. NAME OF CEMETERY OR CREMATORY Carson Valley Cemetery	22d. LOCATION (City, town, or county) (State) Cross Keys Penn.
23. FUNERAL DIRECTOR'S SIGNATURE W. H. Connelley		24a. REC'D BY REGISTRAR DEC 11 1957	
ADDRESS Laurel, Md.		24b. REGISTRAR'S SIGNATURE W. H. Connelley	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEC 11 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13464 CERTIFICATE OF DEATH

13468

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly, Md c. LENGTH OF STAY IN 1b 2 Hours d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY PG. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale, Md d. STREET ADDRESS 6306 59th Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Frances Middle Margaret Last Elizabeth Haugh		4. DATE OF DEATH Month Dec. Day 23 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-3-57
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY Child	9. AGE (In years last birthday) yrs. 8 IF UNDER 1 YEAR: Months 8 Days 8 Hours 8 Min. 8
11. BIRTHPLACE (State or foreign country) Cheverly, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert L. Haugh		14. MOTHER'S MAIDEN NAME Thelma E. Northrop	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Robert Haugh (Father)		Address Same as above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Secondary Infection Over 754.4 DUE TO Congenital Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 3 hrs. (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Dec. 23 , 19 57 , to Dec. 23 , 19 57 , that I last saw the deceased alive on Dec. 23 , 19 57 , and that death occurred at 10:45 A.M. , from the causes and on the date stated above. Dr. Van Helderer / Dr. E. Gaerlren ACTUAL SIGNATURE M.D. 12/23/57 PHYSICIAN'S NAME (Type) Prince George General Hosp.			
22a. BURIAL, CREMATION, OR OTHER DISPOSITION (Specify) Burial	22b. DATE THEREOF 12/26/57	22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery	22d. LOCATION (City, town, or county) (State) Bladensburg, Maryland.
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers		24. REGISTERED BY REGISTRAR Riverdale, Md DATE DEC 26 '57	24b. REGISTRAR'S SIGNATURE Overhiser

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 18

BUREAU V. E.

1957 12 17

RECEIVED

12/17/57
11
11

13465 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel Maryland				c. LENGTH OF STAY IN 1b 10 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Laurel General Hospital, Inc.				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 41 Laurel			
f. STREET ADDRESS 817 Montgomery				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Mary Ella Haynes				4. DATE OF DEATH December 30 19 57			
5. SEX female white				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH July 7, 1873				9. AGE (In years last birthday) 84 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) Laurel, Maryland				12. CITIZEN OF WHAT COUNTRY? United States			
13. FATHER'S NAME James Brown				14. MOTHER'S MAIDEN NAME Shorts, Mary			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT from hospital records				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Hypertension DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 10 Yrs 10 Yrs							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19							
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 12/20 , 19 57 , to 12/30 , 19 57 , that I last saw the deceased alive on 12/29 , 19 57 , and that death occurred at 12/30 A.M., from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) Laurel, Maryland							
DATE SIGNED 12/31/57							
ACTUAL SIGNATURE John M. Warren, M. D.							
PHYSICIAN'S NAME (Type) John M. Warren, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Jan 1, 1958							
22b. DATE THEREOF							
22c. NAME OF CEMETERY OR CREMATORY Long Hill Cemetery Laurel, Maryland							
22d. LOCATION (City, town, or county) (State)							
23. FUNERAL DIRECTOR'S SIGNATURE DeWitt Donaldson Laurel, Md							
ADDRESS							
24a. REC'D BY REGISTRAR 1958							
24b. REGISTRAR'S SIGNATURE A. H. H. H. H.							

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH							
JAMES H. HARRIS		45		M		W		1880		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		JAN 3 1938		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE							
MARRIAGE		DATE		PLACE		CITY		COUNTY		STATE		COUNTRY		DATE		PLACE		CITY		COUNTY		STATE		COUNTRY		DATE		PLACE		CITY		COUNTY		STATE		COUNTRY	
MARRIED		JAN 1 1915		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE			
MARRIAGE		DATE		PLACE		CITY		COUNTY		STATE		COUNTRY		DATE		PLACE		CITY		COUNTY		STATE		COUNTRY		DATE		PLACE		CITY		COUNTY		STATE		COUNTRY	
MARRIED		JAN 1 1915		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE			

BUREAU V. 3

JAN 3 1938

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

13470

13466

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				MARYLAND c. LENGTH OF STAY IN 1b 33 Hours				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bladensburg				d. STREET ADDRESS 4109 Edmonston Rd.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Rose Alice Heller				First Middle Last				4. DATE OF DEATH Month December Day 31 Year 19 57									
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan-18-1876		9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months 11		IF UNDER 24 HRS. Days 12		Hours 19		Min. 57	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY At Home				11. BIRTHPLACE (State or foreign country) Washington, D. C.				12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Charles Barr				14. MOTHER'S MAIDEN NAME Mary Katherine Powers													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None				17. INFORMANT Alice H. Denney				Address 3900 Hamilton St., Hyatts., Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolus Left P. Art. 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pul. Cong. & Edema DUE TO (c) Arterio Sclerosis Ht. Dis.																	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																	
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)																	
21. I certify that I attended the deceased from 19 57 to 12-30- 19 57 , that I last saw the deceased alive on 12-30- 19 57 , and that death occurred at 1 P. M, from the causes and on the date stated above.																	
ACTUAL SIGNATURE Albert Roth PHYSICIAN'S NAME (Type) Dr. Albert Roth				ADDRESS (Street, city or town, state) Riverdale, Maryland.				DATE SIGNED 12-31-57									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Jan. 2, 1958				22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery				22d. LOCATION (City, town, or county) (State) Bladensburg, Maryland.					
23. FUNERAL DIRECTOR'S SIGNATURE W. W. CHAMBERS CO.,				ADDRESS Riverdale, Md.				24a. REC'D BY REGISTRAR JAN 6 1958				24b. REGISTRAR'S SIGNATURE A. Hedrick					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

JAN 6 1958

RECEIVED

CERTIFICATE OF DEATH

DATE OF DEATH

NAME OF DECEASED
 SEX
 AGE
 PLACE OF BIRTH
 OCCUPATION
 MARITAL STATUS
 COLOR
 RELIGION
 PLACE OF DEATH
 DATE OF DEATH
 TIME OF DEATH
 CAUSE OF DEATH
 MANNER OF DEATH
 SIGNATURE OF PHYSICIAN
 SIGNATURE OF WITNESSES
 SIGNATURE OF CORONER
 SIGNATURE OF JURY
 SIGNATURE OF DEPUTY COMMISSIONER
 SIGNATURE OF CLERK

NAME OF DECEASED
 SEX
 AGE
 PLACE OF BIRTH
 OCCUPATION
 MARITAL STATUS
 COLOR
 RELIGION
 PLACE OF DEATH
 DATE OF DEATH
 TIME OF DEATH
 CAUSE OF DEATH
 MANNER OF DEATH
 SIGNATURE OF PHYSICIAN
 SIGNATURE OF WITNESSES
 SIGNATURE OF CORONER
 SIGNATURE OF JURY
 SIGNATURE OF DEPUTY COMMISSIONER
 SIGNATURE OF CLERK

BUREAU V. S.

DEC 6 1931

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13519

CERTIFICATE OF DEATH

Reg. Dist. No.

13472

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY -			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. LENGTH OF STAY IN 1b 6 months & 10 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital				d. STREET ADDRESS 815 M. St., N. W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Asa Middle - Last Hollars				4. DATE OF DEATH Month 12 Day 10 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 3/1/1900		9. AGE (In years last birthday) yrs. 57		IF UNDER 1 YEAR Months - Days - Hours - Min. -
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck driver and roofing		10b. KIND OF BUSINESS OR INDUSTRY Hamilton Roof Repairs		11. BIRTHPLACE (State or foreign country) N. Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Israel Hollars				14. MOTHER'S MAIDEN NAME Mary Isaac			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Decedent			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary tuberculosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 2 yrs., 8 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary emphysema						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5/31, 19 57, to 12/10, 19 57, that I last saw the deceased alive on 12/10, 19 57, and that death occurred at 4:10 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Glenn Dale Hospital 12/10/57 Glenn Dale, Md.							
ACTUAL SIGNATURE Moe Weiss				M.D. Glenn Dale Hospital 12/10/57			
PHYSICIAN'S NAME (Type) Moe Weiss, M. D.				Glenn Dale, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12.14.57		22c. NAME OF CEMETERY OR CREMATORY Mount Olivet		22d. LOCATION (City, town, or county) (State) Washington D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Walsh Funeral Home				ADDRESS 441-11 St. E.		24a. REC'D BY REGISTRAR DATE DEC 16 '57	
				24b. REGISTRAR'S SIGNATURE			

BUREAU V. S.

DEC 16 1957

RECEIVED

13434 CERTIFICATE OF DEATH

Reg. Dist. No.

245

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>15 Hyattsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7708-West Park Drive</u>				d. STREET ADDRESS <u>17408 WEST PARK DR.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ELEANOR JANE M. HOLLIDAY</u>				4. DATE OF DEATH Month Day Year <u>12-30 1957</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-15-1898</u>	
9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Punch Card Operator</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Government</u>		11. BIRTHPLACE (State or foreign country) <u>Massachusetts</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Michael M^c Donley</u>				14. MOTHER'S MAIDEN NAME <u>Eleanor M^c Donald</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Yes</u>		17. INFORMANT Address <u>Eleanor Baker 7408-W. Park Dr. Hyattsville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized carcinomatous</u> <u>193X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>cervical carcinoma</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u> <u>27</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>Jan</u> 19 <u>55</u> , to <u>Dec 30</u> 19 <u>57</u> , that I last saw the deceased alive on <u>Dec 4</u> 19 <u>57</u> , and that death occurred at <u>3 a</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Efrain Guerrero</u>				ADDRESS (Street, city or town, state) <u>901 20th St. N.W.</u>			
PHYSICIAN'S NAME (Type) <u>EFRAIN GUERRERO</u>				DATE SIGNED _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-2-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Washington Natl.</u>		22d. LOCATION (City, town, or county) (State) <u>Smithland Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>W. W. Chambers Co. 517-11th St. S. E.</u>				24a. REC'D BY REGISTRAR <u>JAN 3 1958</u>		24b. REGISTRAR'S SIGNATURE <u>James S. ...</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

IAN 3 1958

BUREAU V. 2

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD	
CERTIFICATE OF DEATH	
Reg. Dist. No.	
1. NAME OF DECEASED	
2. SEX	
3. AGE	
4. DATE OF BIRTH	
5. PLACE OF BIRTH	
6. OCCUPATION	
7. CAUSE OF DEATH	
8. PLACE OF DEATH	
9. TIME OF DEATH	
10. SIGNATURE OF DECEASED	
11. SIGNATURE OF WITNESS	
12. SIGNATURE OF PHYSICIAN	
13. SIGNATURE OF CORONER	
14. SIGNATURE OF JURY	
15. SIGNATURE OF JUDGE	
16. SIGNATURE OF CLERK	
17. SIGNATURE OF REGISTRAR	
18. SIGNATURE OF DECEASED	
19. SIGNATURE OF WITNESS	
20. SIGNATURE OF PHYSICIAN	
21. SIGNATURE OF CORONER	
22. SIGNATURE OF JURY	
23. SIGNATURE OF JUDGE	
24. SIGNATURE OF CLERK	
25. SIGNATURE OF REGISTRAR	
26. SIGNATURE OF DECEASED	
27. SIGNATURE OF WITNESS	
28. SIGNATURE OF PHYSICIAN	
29. SIGNATURE OF CORONER	
30. SIGNATURE OF JURY	
31. SIGNATURE OF JUDGE	
32. SIGNATURE OF CLERK	
33. SIGNATURE OF REGISTRAR	
34. SIGNATURE OF DECEASED	
35. SIGNATURE OF WITNESS	
36. SIGNATURE OF PHYSICIAN	
37. SIGNATURE OF CORONER	
38. SIGNATURE OF JURY	
39. SIGNATURE OF JUDGE	
40. SIGNATURE OF CLERK	
41. SIGNATURE OF REGISTRAR	
42. SIGNATURE OF DECEASED	
43. SIGNATURE OF WITNESS	
44. SIGNATURE OF PHYSICIAN	
45. SIGNATURE OF CORONER	
46. SIGNATURE OF JURY	
47. SIGNATURE OF JUDGE	
48. SIGNATURE OF CLERK	
49. SIGNATURE OF REGISTRAR	
50. SIGNATURE OF DECEASED	
51. SIGNATURE OF WITNESS	
52. SIGNATURE OF PHYSICIAN	
53. SIGNATURE OF CORONER	
54. SIGNATURE OF JURY	
55. SIGNATURE OF JUDGE	
56. SIGNATURE OF CLERK	
57. SIGNATURE OF REGISTRAR	
58. SIGNATURE OF DECEASED	
59. SIGNATURE OF WITNESS	
60. SIGNATURE OF PHYSICIAN	
61. SIGNATURE OF CORONER	
62. SIGNATURE OF JURY	
63. SIGNATURE OF JUDGE	
64. SIGNATURE OF CLERK	
65. SIGNATURE OF REGISTRAR	
66. SIGNATURE OF DECEASED	
67. SIGNATURE OF WITNESS	
68. SIGNATURE OF PHYSICIAN	
69. SIGNATURE OF CORONER	
70. SIGNATURE OF JURY	
71. SIGNATURE OF JUDGE	
72. SIGNATURE OF CLERK	
73. SIGNATURE OF REGISTRAR	
74. SIGNATURE OF DECEASED	
75. SIGNATURE OF WITNESS	
76. SIGNATURE OF PHYSICIAN	
77. SIGNATURE OF CORONER	
78. SIGNATURE OF JURY	
79. SIGNATURE OF JUDGE	
80. SIGNATURE OF CLERK	
81. SIGNATURE OF REGISTRAR	
82. SIGNATURE OF DECEASED	
83. SIGNATURE OF WITNESS	
84. SIGNATURE OF PHYSICIAN	
85. SIGNATURE OF CORONER	
86. SIGNATURE OF JURY	
87. SIGNATURE OF JUDGE	
88. SIGNATURE OF CLERK	
89. SIGNATURE OF REGISTRAR	
90. SIGNATURE OF DECEASED	
91. SIGNATURE OF WITNESS	
92. SIGNATURE OF PHYSICIAN	
93. SIGNATURE OF CORONER	
94. SIGNATURE OF JURY	
95. SIGNATURE OF JUDGE	
96. SIGNATURE OF CLERK	
97. SIGNATURE OF REGISTRAR	
98. SIGNATURE OF DECEASED	
99. SIGNATURE OF WITNESS	
100. SIGNATURE OF PHYSICIAN	

RECEIVED
JAN 3 1958
BUREAU V. 2

13467 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltsville</u> X/			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eugene Leland Memorial Hospital</u>				d. STREET ADDRESS <u>Gun Powder Road</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Mette</u> Middle <u>Christine</u> Last <u>Jacobsen</u>				4. DATE OF DEATH Month <u>December</u> Day <u>20</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 29, 1865</u>	
9. AGE (In years last birthday) <u>92</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Denmark</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Christian Jensen Skovføjle</u>				14. MOTHER'S MAIDEN NAME <u>Dorothy Hall</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>Hospital Records</u>			
17. INFORMANT <u>Hospital Records</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure.</u> <u>450.0</u> DUE TO <u>General arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>1 week</u> DUE TO (c) <u>10 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260X</u> <u>Diabetes</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>1950</u> to <u>Dec 20, 1957</u> , that I last saw the deceased alive on <u>Dec 19, 1957</u> , and that death occurred at <u>10:30</u> M, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>L W Malin</u> M.D. <u>Riverdale, Md.</u> <u>Dec 20, 1957</u>							
PHYSICIAN'S NAME (Type) <u>L W Malin M.D.</u> <u>RIVERDALE, MD.</u>							
22a. BURIAL CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Transportation</u>		<u>12/21/57</u>		<u>West Lawn</u>		<u>Omaha, Nebraska</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u> <u>Hyattsville, Maryland.</u>				24a. REC'D BY REGISTRAR DATE <u>12/30/57</u>		24b. REGISTRAR'S SIGNATURE <u>James Henry</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 31 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>On Geo</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>same</i> b. COUNTY <i>same</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville</i>		c. LENGTH OF STAY IN 1b <i>45 yr</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>5319-42nd Ave</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>GEORGE SHEARMAN JAMES</i>		4. DATE OF DEATH <i>Dec 8 1957</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Apr 14, 1869</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Teller</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Banking</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13. FATHER'S NAME <i>Charles H. James</i>		14. MOTHER'S MAIDEN NAME <i>Matilda Valinda Naylor</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Miss Addie James</i>	
17. INFORMANT <i>as above</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chronic Congestive Heart Failure</i> <i>450.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Generalized arterio-sclerosis</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1955</i> , 19 <i>Dec 57</i> , to <i>Dec 8 1957</i> , that I last saw the deceased alive on <i>Dec 6 1957</i> , and that death occurred at <i>12 noon</i> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>4713-Brandy Rd</i> DATE SIGNED <i>12/8/57</i>			
ACTUAL SIGNATURE <i>W. L. Etienne</i> M.D.		PHYSICIAN'S NAME (Type) <i>W. L. ETIENNE</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Dec 10, 1957</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Congressional</i>		22d. LOCATION (City, town, or county) (State) <i>Washington D. C.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>F. Gasch's Sons</i> ADDRESS <i>Hyattsville, Md.</i>		24a. REC'D BY REGISTRAR <i>James Henry</i> 24b. REGISTRAR'S SIGNATURE <i>James Henry</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13476

13468 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 20 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Seat Pleasant	
3. NAME OF DECEASED (Type or print) Patricia A Baby Girl 7		4. DATE OF DEATH Month December Day 22 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-3-57
9. AGE (In years last birthday) 7 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 20 Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) MD		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME David Pensinger		14. MOTHER'S MAIDEN NAME Patricia Jarboe	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] No		16. SOCIAL SECURITY NO. —	
17. INFORMANT Catherine Jarboe		Address 6402 F St NW, Seat Pleasant, MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 752 X DUE TO Pulmonary Edema Hydrocephalus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Meningococci, Lumbar, Spinal Bifida		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-3-57 to 12-22-57, that I last saw the deceased alive on 12-22-57, and that death occurred at 5:25 P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE John W. Perkins		DATE SIGNED 12/23/57	
PHYSICIAN'S NAME (Type) Dr. John Perkins		ADDRESS (Street, city or town, state) 5301 Hamilton St., Hyattsville, MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-24-57	
22c. NAME OF CEMETERY OR CREMATORY M.T.O. Tivet		22d. LOCATION (City, town, or county) (State) Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE W W Chambers		24a. REC'D BY REGISTRAR DATE DEC 27 57	
24b. REGISTRAR'S SIGNATURE W. Beach			

2077181XV5

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13469 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13477

Reg. Dist. No.

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b Dead on arrival		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North Forestville X2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital			d. STREET ADDRESS 3420 81st		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Mary Middle Frances Last Jenkins			4. DATE OF DEATH Month December Day 1 Year 19 57		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 4, 1920		9. AGE (In years last birthday) 37 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife Own Home		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) District of Columbia	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Louis M. Pugh			14. MOTHER'S MAIDEN NAME Ruth Kerlin		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Address Grady Fay Jenkins, same as # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: 434.1 IMMEDIATE CAUSE (a) Toxemia, congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>James I. Boyd</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) James I. Boyd		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) 12/4/57		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill	
22d. LOCATION (City, town, or county) (State) Switzland Md		22e. REGISTRAR'S SIGNATURE <i>Lee Funeral Home</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Lee Funeral Home</i>		ADDRESS 300-4th st N.E.		24a. REC'D BY REGISTRAR DATE DEC 4 '57	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF MARYLAND

NAME OF DECEASED: [illegible]
RESIDENCE: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE OF EXAMINER: [illegible]
DATE: [illegible]

RECEIVED
DEC 4 1957
BUREAU V. 2

13470

CERTIFICATE OF DEATH

13478

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George				MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland				b. COUNTY Prince George					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 4 days				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale Heights				25					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General								d. STREET ADDRESS 5906 Sheridan Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Anna				Middle Marie				Last Johnson				4. DATE OF DEATH Month 12		Day 16		Year 1957	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-24-1901		9. AGE (In years lost birthday) 56 yrs.		IF UNDER 1 YEAR Months 56		IF UNDER 24 HRS. Days 16		Hours 1957			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cannaphon to Elderly				10b. KIND OF BUSINESS OR INDUSTRY Private Home				11. BIRTHPLACE (State or foreign country) Weston, W.Va.				12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Martin J. Tighe								14. MOTHER'S MAIDEN NAME Catherine Ford									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None				17. INFORMANT Mary K. Barton				Address Riverdale Hgts. Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332X Massive Cerebral Thrombosis. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized ARTERIOSCLEROSIS. DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)								20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from 12-12 , 19 57 , to 12-16 , 19 57 , that I last saw the deceased alive on 12 , and that death occurred at 12:20PM , from the causes and on the date stated above.																	
ACTUAL SIGNATURE Henry R. Wolfe								ADDRESS (Street, city or town, state) 905 SHILOH ST. HYATTSVILLE MD.									
DATE SIGNED 12-16-57																	
PHYSICIAN'S NAME (Type) Dr. Henry Wolfe																	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 12/18/1957				22c. NAME OF CEMETERY OR CREMATORY Washington Nat'l Cem.				22d. LOCATION (City, town, or county) (State) Suitland Rd. Pr. Geo. Co. Md.					
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.								ADDRESS DEC 19 57				24a. REC'D BY REGISTRAR DEC 19 57					
								24b. REGISTRAR'S SIGNATURE Dec 19 57									

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

1903

NAME OF DECEASED

RESIDENCE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

DATE OF BIRTH

EDUCATION

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

BUREAU V. 2

DEC 19 1903

RECEIVED

Items 10c, 11, 12, 13, 14, 15 Film G224 1-20-58 et
13471 CERTIFICATE OF DEATH

13479

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 7 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's General Hosp				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 14 College Park, Maryland			
d. STREET ADDRESS 5026 Lakeland Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Joseph C Johnson				4. DATE OF DEATH Month Day Year Dec 6 19 57			
5. SEX M		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1 Oct 1895	
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver				10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (State or foreign country) Alexandria, Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John C. Johnson				14. MOTHER'S MAIDEN NAME Sara E. Butler (Johnson)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes 18/5/18-12/6/18				16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Massive Intraventricular Hemorrhage Rk Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 1 Septicemic Arterio Sclerosis Atherosclerosis DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 1 Dec 19 57, to 6 Dec 19 57, that I last saw the deceased alive on 6 Dec 19 57, and that death occurred at M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE				M.D. John A. Kelly			
PHYSICIAN'S NAME (Type)							
22a. (BURIAL) CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 12-11-57		22c. NAME OF CEMETERY OR CREMATORY Arlington Cemetery Ft Myers Va		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE W. Ernest Garrison 1432 Fox St W.				24a. REC'D BY REGISTRAR DATE DEC 11 57		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form No. 10

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF DECEASED	
JAMES H. HARRIS		Male		45		White		1880		Maryland		1925		Baltimore		Heart Disease		Natural		J. H. Harris		J. H. Harris	
13. OCCUPATION		14. EDUCATION		15. RELIGION		16. MARITAL STATUS		17. PREVIOUS ILLNESS		18. PREVIOUS SURGERY		19. PREVIOUS TRAUMA		20. PREVIOUS DRUGS		21. PREVIOUS ALCOHOL		22. PREVIOUS TOBACCO		23. PREVIOUS OTHER		24. PREVIOUS OTHER	
Teacher		High School		Roman Catholic		Married		None		None		None		None		None		None		None		None	
25. PREVIOUS OTHER		26. PREVIOUS OTHER		27. PREVIOUS OTHER		28. PREVIOUS OTHER		29. PREVIOUS OTHER		30. PREVIOUS OTHER		31. PREVIOUS OTHER		32. PREVIOUS OTHER		33. PREVIOUS OTHER		34. PREVIOUS OTHER		35. PREVIOUS OTHER		36. PREVIOUS OTHER	
None		None		None		None		None		None		None		None		None		None		None		None	
37. PREVIOUS OTHER		38. PREVIOUS OTHER		39. PREVIOUS OTHER		40. PREVIOUS OTHER		41. PREVIOUS OTHER		42. PREVIOUS OTHER		43. PREVIOUS OTHER		44. PREVIOUS OTHER		45. PREVIOUS OTHER		46. PREVIOUS OTHER		47. PREVIOUS OTHER		48. PREVIOUS OTHER	
None		None		None		None		None		None		None		None		None		None		None		None	
49. PREVIOUS OTHER		50. PREVIOUS OTHER		51. PREVIOUS OTHER		52. PREVIOUS OTHER		53. PREVIOUS OTHER		54. PREVIOUS OTHER		55. PREVIOUS OTHER		56. PREVIOUS OTHER		57. PREVIOUS OTHER		58. PREVIOUS OTHER		59. PREVIOUS OTHER		60. PREVIOUS OTHER	
None		None		None		None		None		None		None		None		None		None		None		None	

BUREAU V. S.

DEC 11 1925

RECEIVED

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13480
Reg. Dist. No.

13472

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. STREET ADDRESS 5906 K. Street	
3. NAME OF DECEASED (Type or print) Arthur Welton Judd		4. DATE OF DEATH December 24, 1957	
5. SEX Male	6. COLOR OR RACE colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 13, 1905
9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR Days	IF UNDER 24 HRS. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Presser		10b. KIND OF BUSINESS OR INDUSTRY Tailoring	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U,S,A.	
13. FATHER'S NAME Oscar Judd		14. MOTHER'S MAIDEN NAME Anne P. Barbour	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Irene J. Judd; same adress as # 2.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral compression 330x DUE TO Conditions, if any, which gave rise to immediate cause (b) Subarachnoid hemorrhage (c) Rupture of aneurism of posterior cerebral artery PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. DATE THEREOF 12-28-57		22b. NAME OF CEMETERY OR CREMATORY Lincoln Memorial	
22c. LOCATION (City, town, or county) Sutland		(State) 7nd.	
23. FUNERAL DIRECTOR'S SIGNATURE Henry S. Washington & Sons		ADDRESS 467 N St. N.W. Wash. D.C.	
24a. REC'D BY REGISTRAR DEC 30 57		DATE	
24b. REGISTRAR'S SIGNATURE			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH

NAME: [illegible]
AGE: [illegible]
SEX: [illegible]
RACE: [illegible]
DATE OF BIRTH: [illegible]
PLACE OF BIRTH: [illegible]
OCCUPATION: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE: [illegible]
DATE: [illegible]

BUREAU V. 1

EC 20 1967

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13520 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

134814

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairmount Heights		c. LENGTH OF STAY IN 1b X2 Fairmount Heights	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6111 Kolb Street		d. STREET ADDRESS 1 6111 Kolb Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Michele Victoria Kearse		4. DATE OF DEATH Month December Day 3 Year 1957	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-12-57
9. AGE (In years last birthday) yrs. 20		IF UNDER 1 YEAR Months Days Hours Min. 20	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Walter Kearse, Jr.		14. MOTHER'S MAIDEN NAME Reather Govan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Reather Kearse; same address; mother		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 921.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Aspiration of stomach contents DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Aspirated stomach contents	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 12/3 1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) P.G.	
20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED 12-3-57			
22a. BURIAL, CREMATION, REMOVAL (Specify) 12-6-57		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		22d. LOCATION (City, town, or county) 4611-Benning Rd. S.E. Wash. D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Henry S. Washington		ADDRESS 467-7th St. NW	
24a. REC'D BY REGISTRAR DEC 9 1957		24b. REGISTRAR'S SIGNATURE Curie Campbell	

2077/182 XV57

FOR STATE
DEATH CERT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
THE MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
DEC 9 1957
BUREAU V. 5

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13482

13521 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COLMAN MANOR				c. LENGTH OF STAY IN 1b 20 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4311 MONROE ST.				d. STREET ADDRESS 4311 MONROE ST.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First HANNAH Middle KERSHAW Last KERSHAW				4. DATE OF DEATH Month Dec Day 7 Year 1957			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH SEPT. 26, 1877	
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) SHAW, LANCS., ENGLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ALBERT FARROW				14. MOTHER'S MAIDEN NAME ELIZA LEATHERBORROW			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NO		17. INFORMANT ALBERT F. KERSHAW SON Address 4311 MONROE ST COLMAN MANOR MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 48 hrs 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from SEPT 15 , 19 57 , to 12/7 , 19 57 , that I last saw the deceased alive on 12/7 , 19 57 , and that death occurred at 7 A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Norman Donat Cromeau M.D.				ADDRESS (Street, city or town, state) 3503 PENNY ST			
PHYSICIAN'S NAME (Type) NORMAN DONAT CROMEAU				DATE SIGNED 12/7/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF Dec 9, 1957		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colman Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Md.				24a. REC'D BY REGISTRAR DEC 10 57		24b. REGISTRAR'S SIGNATURE	

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13522

CERTIFICATE OF DEATH

13483/34

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Pr. George's County</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission), a. STATE <i>md.</i> b. COUNTY <i>Pr. George's Cty.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Forestville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>*2 Forestville, Maryland.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>3704-81st Ave.</i>		d. STREET ADDRESS <i>13704-81st Ave.</i>	
3. NAME OF DECEASED (Type or print) <i>Helen J. Ketchel</i> First Middle		4. DATE OF DEATH <i>Dec. 26, 1957</i> Month Day Year	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept. 17, 1892</i>
9. AGE (In years last birthday) <i>65</i> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Unemployed</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Greece</i>	
11. BIRTHPLACE (State or foreign country) <i>Greece</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>George G. Gillespie</i>		14. MOTHER'S MAIDEN NAME <i>Josephine - (Unknown)</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>(Son -) Jack N. Ketchel</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>PULMONARY EDEMA</i> DUE TO (b) <i>434.1</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <i>Congestive heart Failure</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Dec. 10, 1957</i> to <i>Dec. 26, 1957</i> , that I last saw the deceased alive on <i>Dec. 26, 1957</i> , and that death occurred at <i>6:45 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Bruno Kolega</i>		ADDRESS (Street, city or town, state) <i>7200 - MARLBORO RD. S.E. 17/45</i>	
PHYSICIAN'S NAME (Type) <i>Bruno Kolega</i>		DATE SIGNED <i>Dec. 26, 1957</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>12-28-57</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Switzland, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. W. Chamberlin</i>		ADDRESS <i>517-11th St. S.E.</i>	
24a. REC'D BY REGISTRAR <i>AN 6</i>		24b. REGISTRAR'S SIGNATURE <i>Carrie Campbell</i>	

BUREAU V. S.

JAN 6 1953

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

13523 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13484

Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clinton		c. LENGTH OF STAY IN 1b 5 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clinton			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS Piscataway Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Whitney Middle Paul Last King				4. DATE OF DEATH Month December Day 5 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 1892	
				9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James King				14. MOTHER'S MAIDEN NAME Rose Lee Edelen			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address Joseph Sanders King, Clinton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442x DUE TO Acute congestive heart failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Dec. 9, 1957		22c. NAME OF CEMETERY OR CREMATORY Oakland Cem.	
22d. LOCATION (City, town, or county) State) Waldorf Maryland				23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS South Funeral Home, Waldorf, Md.			
24a. REC'D BY REGISTRAR DATE 12/9/57				24b. REGISTRAR'S SIGNATURE Carrie Campbell			

DEC 11 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13439 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13485
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt Rainier Md.		c. LENGTH OF STAY in 1b 8 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2403 Arundel Rd		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Theresa Joan Kott		4. DATE OF DEATH Dec. 18, 19 57	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec 12, 1957
9. AGE (In years last birthday) yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME John Harvey Kott		14. MOTHER'S MAIDEN NAME Ida Josephine Perello	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT John Harvey Kott		Address Mt Rainier, Maryland.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 763.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Bronchopneumonia (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John T. Maloney		DATE SIGNED December 19, 1957	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/21/57	
22c. NAME OF CEMETERY OR CREMATORY St. Marys Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. - 2901 14th St., N.W. - Washington 9, D.C.		24a. REC'D BY REGISTRAR DEC 23 1957	
24b. REGISTRAR'S SIGNATURE James Levere			

2077201XV5

25

BUREAU V. S.

DEC 23 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13473

CERTIFICATE OF DEATH

13486

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel (Rural)		c. LENGTH OF STAY IN 1b 6 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel (Rural)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Box #32 Route #2			d. STREET ADDRESS Box #32 Route #2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) FLORENCE AGNES KRAFT			4. DATE OF DEATH December 12th, 1957		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 11th, 1890	9. AGE (In years lost birthday) 67 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk (Retired)			10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't Bu. of Engraving		11. BIRTHPLACE (State or foreign country) Forestville, Md.
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Elisha Ferguson		
14. MOTHER'S MAIDEN NAME Victoria Richardson			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		
16. SOCIAL SECURITY NO. None			17. INFORMANT Mary Alice Hemp, 2518 Avalon Pl. Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Peritonitis 170x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Lacy Rt Breast. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Heart Failure.					INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour a. ft. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 1957 , 19____, to the 11 19____ that I last saw the deceased alive on Dec 11 19____, and that death occurred at 12:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Forestville, Maryland DATE SIGNED Dec 12, 1957					
ACTUAL SIGNATURE Robert C. Wingfield M.D.					
PHYSICIAN'S NAME (Type) ROBERT C. WINGFIELD					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY	
BURIAL		12/16/57		Fort Lincoln Cemetery	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co. 517--11th St. S.E.		ADDRESS Wash. DC		24a. REC'D BY REGISTRAR DATE DEC 16 57	
24b. REGISTRAR'S SIGNATURE Ans. Smith					

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF BIRTH May 19, 1922	
5. PLACE OF BIRTH Jackson, Tennessee		6. OCCUPATION None		7. MARITAL STATUS Single		8. COLOR White	
9. DATE OF DEATH April 4, 1968		10. PLACE OF DEATH Memphis, Tennessee		11. CAUSE OF DEATH Fired by sniper		12. MANNER OF DEATH Homicide	
13. SIGNATURE OF DECEASED (None)		14. SIGNATURE OF NEXT OF KIN (None)		15. SIGNATURE OF PHYSICIAN (None)		16. SIGNATURE OF CORONER (None)	
17. SIGNATURE OF REGISTRAR (None)		18. SIGNATURE OF CLERK (None)		19. SIGNATURE OF JUDGE (None)		20. SIGNATURE OF SHERIFF (None)	

BUREAU V. 2

DEC 16 1957

RECEIVED

12/1/77

13524

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 28 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle Kraft Last Kraft				4. DATE OF DEATH Month Dec. Day 23 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/7/1898	
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months 59		IF UNDER 24 HRS. Days 59 Hours 59 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lineman D.C. Transit				10b. KIND OF BUSINESS OR INDUSTRY Wash. D.C.		11. BIRTHPLACE (State or foreign country) U.S.A.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John A. Kraft				14. MOTHER'S MAIDEN NAME Pauline - Lauffer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Robert A. Kraft - 622 Platanus Pl				Address 622 Platanus Pl			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic Cancer 156.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Malignant Hepatoma with DUE TO (c) generalized Metastasis						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 1, 19 57 to Dec. 23, 19 57 , that I last saw the deceased alive on Dec. 22, 19 57 , and that death occurred at 3:15 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 622 Platanus Pl DATE SIGNED Dec 27 57							
ACTUAL SIGNATURE Peter Heuer M.D.							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
12/26/57		Orl Nat Cem		Arlington - Va.			
23. FUNERAL DIRECTOR'S SIGNATURE J. M. Lee Funeral Home				ADDRESS 360 1st St N.E.		24a. REC'D BY REGISTRAR Dec 27 57	
				24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—HARTFORD ONE 18

DATE OF DEATH
1957

DATE OF DEATH
1957

RECEIVED
DEC 27 1957
BUREAU V. S.

13525

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Prince Georges</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Washington</u> <u>D.C.</u> <u>47X-3</u> b. COUNTY <u>Washington</u> <u>D.C.</u> <u>47X-3</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. LENGTH OF STAY IN 1b <u>2 hrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General Hospital</u>				d. STREET ADDRESS <u>1215 Savannah St. S.E.</u>			
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Boy</u> Last <u>Krueger</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>5</u> Year <u>19 57</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5 Dec. 1957</u>	
9. AGE (In years last birthday) <u>2</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
				11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John William Jr.</u>				14. MOTHER'S MAIDEN NAME <u>Shirley J. Freeman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mother</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>757.3 Assoc. E. 1. Cong. abnorm. left kidney</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>both ureters and the urinary bladder</u> DUE TO (c) <u>2. Hypoplasia of kidney</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>19</u> Month, Day, Year		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12/5</u> , 19 <u>57</u> to <u>12/5</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12/5</u> , 19 <u>57</u> , and that death occurred at <u>2:20 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>524184, Benches Rd, Wash 21, DC</u> DATE SIGNED <u>12/9/57</u>							
ACTUAL SIGNATURE <u>John T. Lynn</u> M.D.				PHYSICIAN'S NAME (Type) <u>Dr. John Lynn Togg</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>cremation</u>		22b. DATE THEREOF <u>12/11/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Prince George's General Hospital, Cheverly, Md.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harry W. Penn, Jr., Administrator</u> ADDRESS				24a. REC'D BY REGISTRAR <u>DEC 17 57</u>		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF BIRTH 12-1-22		5. PLACE OF BIRTH MOBILE, ALA.	
6. OCCUPATION Singer		7. MARITAL STATUS Single		8. COLOR White		9. HEIGHT 5' 10"		10. WEIGHT 175	
11. CAUSE OF DEATH Suicide		12. MANNER OF DEATH Homicide		13. PLACE OF DEATH MEMPHIS, TENN.		14. DATE OF DEATH 4-4-68		15. TIME OF DEATH 11:00 AM	
16. SIGNATURE OF DECEASED [Signature]		17. SIGNATURE OF WITNESS [Signature]		18. SIGNATURE OF PHYSICIAN [Signature]		19. SIGNATURE OF CORONER [Signature]		20. SIGNATURE OF JURY [Signature]	

BUREAU V. 2

DEC 17 1967

RECEIVED

13526

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges				b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 3 Days				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 14 College Park																															
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Geo rges General								d. STREET ADDRESS 8500 48th Ave.,								e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																															
3. NAME OF DECEASED (Type or print) First Else Middle Kusterman Last Kusterman				4. DATE OF DEATH Month December Day 15 Year 19 57				5. SEX Female				6. COLOR OR RACE White				7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 5-14-75				9. AGE (In years last birthday) 82 yrs.				10. IF UNDER 1 YEAR Months 82				11. IF UNDER 24 HRS. Hours 82				12. IF UNDER 5 MIN. Min. 82											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife								10b. KIND OF BUSINESS OR INDUSTRY								11. BIRTHPLACE (State or foreign country) Germany								12. CITIZEN OF WHAT COUNTRY? Germany																							
13. FATHER'S NAME Bernhard Sander								14. MOTHER'S MAIDEN NAME Marie Roemer								15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no								16. SOCIAL SECURITY NO. no								17. INFORMANT Else Meyer- 829 Quincy Street, N.W.								Address Wash. D.C.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive arterio sclerosis AT DUE TO (c) Chronic pyelonephritis																INTERVAL BETWEEN ONSET AND DEATH																															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>																															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)																20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																															
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19								20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>								20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)								20f. (City or town) (County) (State)																							
21. I certify that I attended the deceased from 12-12 , 19 57 , to 12-15 , 19 57 , that I last saw the deceased alive on 12-15 , 19 57 , and that death occurred at 9:55 P.M. , from the causes and on the date stated above.																																															
ACTUAL SIGNATURE Henry R. Wolfe																ADDRESS (Street, city or town, state) 3002 Arundel Road, Mt. Rainier, Md.																DATE SIGNED 12/15/57															
PHYSICIAN'S NAME (Type) Dr. Henry Wolfe																																															
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial								22b. DATE THEREOF 12/19/57								22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery								22d. LOCATION (City, town, or county) (State) Prince Georges County, Md.																							
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.																ADDRESS 2901 14th St. N.W. Washington 9, D.C.																24a. REC'D BY REGISTRAR DATE DEC 18 57								24b. REGISTRAR'S SIGNATURE Rebecca							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		DATE OF DEATH	
JAMES J. HANCOCK		45		M		W		JAN 15 1890		JAN 15 1935	
PLACE OF BIRTH		CITY		STATE		COUNTRY		OCCUPATION		CAUSE OF DEATH	
BOSTON		BOSTON		MASSACHUSETTS		UNITED STATES		LABORER		HEART DISEASE	
MANNER OF DEATH		EDUCATION		RELIGION		MARRIAGE		PREVIOUS ILLNESS		POST-MORTEM	
NATURAL		HIGH SCHOOL		CATHOLIC		MARRIED		NONE		NO	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF BURIAL	
J. J. HANCOCK		J. J. HANCOCK		J. J. HANCOCK		J. J. HANCOCK		J. J. HANCOCK		J. J. HANCOCK	

BUREAU V. S.

DEC 18 1937

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

'13527 Item 1 Film G223 12-16-57 et

CERTIFICATE OF DEATH

13491

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>3321-Wintergreen Ave. Prince Georges</i> COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>North Forest Hill</i>	c. LENGTH OF STAY IN 1b <i>6 wks</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>x2 Washington 28 D.C.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>3321 Wintergreen Avenue</i>		d. STREET ADDRESS <i>13321-Wintergreen Ave</i>	
3. NAME OF DECEASED (Type or print) First <i>Ethel</i> Middle <i>—</i> Last <i>Lees</i>		4. DATE OF DEATH Month <i>Dec.</i> Day <i>2</i> Year <i>1957</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>MAY 19, 1898</i>
9. AGE (In years last birthday) <i>59</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	
11. BIRTHPLACE (State or foreign country) <i>Lanes, England</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Herbert E. Smith</i>		14. MOTHER'S MAIDEN NAME <i>Alice Hindle</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT <i>Husband - Christopher Lees</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>150x CARCINOMA OF ESOPHAGUS</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>—</i> DUE TO (c) <i>—</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 1/2 yrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>DECEMBER 25, 1957</i> , to <i>DECEMBER 2, 1957</i> , that I last saw the deceased alive on <i>DECEMBER 2, 1957</i> , and that death occurred at <i>3 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Bruno Klega</i>		ADDRESS (Street, city or town, state) <i>7200 MARIBORO PIKE, SE. Washington 28 D.C.</i>	
PHYSICIAN'S NAME (Type) <i>BRUNO KLEGA</i>		DATE SIGNED <i>12/2/57</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>	22b. DATE THEREOF <i>12-4-57</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Suitland, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>W.W. Chambers Co Washington, DC</i>		24. REC'D BY REGISTRAR <i>DECO</i>	
24b. REGISTRAR'S SIGNATURE <i>Cassie Campbell</i>			

MEDICAL CERTIFICATION

BUREAU V. 5

DEC 9 1957

RECEIVED

13474 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY HOWARD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LAUREL				c. LENGTH OF STAY IN 1b 13 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION LAUREL GENERAL HOSPITAL				d. STREET ADDRESS FULTON			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last JESSE J. LEWIS				4. DATE OF DEATH Month Day Year DEC. 18 1957			
5. SEX MALE	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 5, 1886	9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired farmer own farm				10b. KIND OF BUSINESS OR INDUSTRY Maryland		11. BIRTHPLACE (State or foreign country) U.S.A.	
13. FATHER'S NAME JOHN LEWIS				14. MOTHER'S MAIDEN NAME GEORGIANNA CROSS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown				16. SOCIAL SECURITY NO.		17. INFORMANT Address Clyde Lewis Fulton Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Dis. DUE TO (c) Cerebral Hemorrhage				INTERVAL BETWEEN ONSET AND DEATH 3 yrs. 2 wks.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 5/10, 1954 to 12/18, 1957 , that I last saw the deceased alive on 12/17, 1957 , and that death occurred at 5:41 M, from the causes and on the date stated above.				ADDRESS (Street, city or town, state) DATE SIGNED Laurel, Maryland January 17, 1958			
ACTUAL SIGNATURE J M Warren				PHYSICIAN'S NAME (Type) John M. Warren			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Dec. 20, 1957		22c. NAME OF CEMETERY OR CREMATORY St Pauls Cem.	
22d. LOCATION (City, town, or county) (State) Fulton Maryland							
23. FUNERAL DIRECTOR'S SIGNATURE De Witt Davidson				ADDRESS Laurel, Md		24a. REC'D BY REGISTRAR DATE	
24b. REGISTRAR'S SIGNATURE W. Deouch							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 12

BUREAU V. S.

DEC 23 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

item 3 Film G224 1-6-50 et

13528

CERTIFICATE OF DEATH

13493

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - CLINTON		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - CLINTON	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RT. 1 Box 611		d. STREET ADDRESS (last) RT. 1 Box 611	
3. NAME OF DECEASED (Type or print) First TERRY Middle LITTLEFIELD Last FARRIS		4. DATE OF DEATH Month DEC. Day 22 Year 1957	
5. SEX MALE	6. COLOR OR RACE WHITE	MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) JULY 30, 1957 yrs. 4 Months 22 Days 22 Hours 22 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY NONE	
11. BIRTHPLACE (State or foreign country) WASH. D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ROY LITTLEFIELD		14. MOTHER'S MAIDEN NAME RENA LITTLEFIELD	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT CHARLES FARRIS Address RT. 1 Box 611 CLINTON			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA, TYPE UNDETERMINED DUE TO 493X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 493X (c) 493X INTERVAL BETWEEN ONSET AND DEATH 24 HRS.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) NONE		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) NONE	
20c. TIME OF INJURY Month, Day, Year NONE 19 1957		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work NONE	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) NONE		20f. (City or town) (County) (State) NONE	
21. I certify that I attended the deceased from AUG. 26, 1957 , to DEC. 22, 1957 , that I last saw the deceased alive on DEC. 21, 1957 , and that death occurred at 6:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Arthur Shaver Jr. M.D.		DATE SIGNED Clinton, Md. Dec. 22, 1957	
PHYSICIAN'S NAME (Type) ARTHUR SHAVER JR.		CLINTON, MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Dec 1957		22b. DATE THEREOF 1957	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co. Washington, D.C.		24a. REC'D BY REGISTRAR Carrie Campbell	
24b. REGISTRAR'S SIGNATURE Carrie Campbell		DATE DEC 30 1957	

CERTIFICATE OF DEATH

Page 1 of 1

Form with multiple sections for recording death information, including fields for name, age, sex, race, cause of death, and place of death. The form is partially filled out with handwritten text.

BUREAU V. H.

DEC 30 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13529 CERTIFICATE OF DEATH

Reg. Dist. No.

13494

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Virginia b. COUNTY -	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Alexandria 83x-3	
c. LENGTH OF STAY IN 1b 1 yr. 7 mos. and 1 day		d. STREET ADDRESS 3600 Appletree Drive	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Samuel - Massey		4. DATE OF DEATH Month Day Year 12 3 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/15/85
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Restaurant employee		10b. KIND OF BUSINESS OR INDUSTRY Cordell's Restaurant NYC, New York	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jacob Massey		14. MOTHER'S MAIDEN NAME Mary ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 054-05-9144	
17. INFORMANT Decedent		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 1 day 10 yrs.,
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary tuberculosis; pulmonary emphysema; cor pulmonale			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 5/2, 19 56, to 12/3, 19 57, that I last saw the deceased alive on 12/3, 19 57, and that death occurred at 12:40AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Glenn Dale Hospital 12/3/57 ACTUAL SIGNATURE Moe Weiss M.D. PHYSICIAN'S NAME (Type) Moe Weiss, M. D. Glenn Dale, Maryland			
22a. BURIAL OR REMOVAL (Specify)	22b. DATE THEREOF 12/5/57	22c. NAME OF CEMETERY OR CREMATORY Mount Zion Cem.	22d. LOCATION (City, town, or county) (State) L.D. 113
23. FUNERAL DIRECTOR'S SIGNATURE B. Dargatzis		ADDRESS 3501-4th ST NW	24a. REC'D BY REGISTRAR DATE DEC 5 '57
		24b. REGISTRAR'S SIGNATURE W. Search	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13530

CERTIFICATE OF DEATH

Reg. Dist. No.

13495

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D. C.</u> b. COUNTY <u>-</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glenn Dale (rural)</u>		c. LENGTH OF STAY IN 1b <u>8 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Glenn Dale Hospital</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> <u>47X-3</u>	
3. NAME OF DECEASED (Type or print) First <u>Owen</u> Middle <u>C.</u> Last <u>McDermott</u>		4. DATE OF DEATH Month <u>12</u> Day <u>19</u> Year <u>19 57</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/9/1904</u>
9. AGE (In years last birthday) <u>53</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>-</u> Days <u>-</u> Hours <u>-</u> Min. <u>-</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Exterminator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MacDonald & Horn</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James McDermott</u>		14. MOTHER'S MAIDEN NAME <u>Suzanna Sheehan</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>-</u>		16. SOCIAL SECURITY NO. <u>578-03-3261</u>	
17. INFORMANT <u>Elizabeth McDermott, Wife, 1511 25th St., SE, #3</u>		Address <u>#3</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cor pulmonale</u> <u>002x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pulmonary emphysema</u> DUE TO (c) <u>Pulmonary tuberculosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u> <u>2 yrs.,</u> <u>3 yrs.,</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pneumonitis, right lung, etiology undetermined</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>DIED FROM THORAX LEFT SPONTANEOUS</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12/11</u> , 19 <u>57</u> , to <u>12/19</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12/19</u> , 19 <u>57</u> , and that death occurred at <u>6:30 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Glenn Dale Hospital</u> DATE SIGNED <u>12/19/57</u>			
ACTUAL SIGNATURE <u>Moe Weiss</u> M.D.		Glenn Dale Hospital	
PHYSICIAN'S NAME (Type) <u>Moe Weiss, M. D.</u>		Glenn Dale, Md.	
22a. BURIAL, CREMATION, REPOSING (Specify)		22b. DATE THEREOF <u>12-23-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jill Lee Son</u> ADDRESS <u>Wash. D. C.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 26 57</u>	
24b. REGISTRAR'S SIGNATURE <u>W. J. Smith</u>			

CERTIFICATE OF DEATH

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON, 18

1957

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. CAUSE OF DEATH		9. PLACE OF DEATH		10. TIME OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
JAMES J. JONES		M		45		1912		NEW YORK		LABORER		MARRIED		HEART DISEASE		HOSPITAL		10:00 AM		J. J. JONES		J. J. JONES	
13. PLACE OF INTERMENT		14. NAME OF INTERMENT		15. DATE OF INTERMENT		16. SIGNATURE OF MINISTER		17. SIGNATURE OF DECEASED		18. SIGNATURE OF WITNESSES		19. SIGNATURE OF DECEASED		20. SIGNATURE OF WITNESSES		21. SIGNATURE OF DECEASED		22. SIGNATURE OF WITNESSES		23. SIGNATURE OF DECEASED		24. SIGNATURE OF WITNESSES	
CATHOLIC CHURCH		ST. JAMES		12/26/57		J. J. JONES		J. J. JONES		J. J. JONES		J. J. JONES		J. J. JONES		J. J. JONES		J. J. JONES		J. J. JONES		J. J. JONES	

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. CAUSE OF DEATH		9. PLACE OF DEATH		10. TIME OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
JAMES J. JONES		M		45		1912		NEW YORK		LABORER		MARRIED		HEART DISEASE		HOSPITAL		10:00 AM		J. J. JONES		J. J. JONES	
13. PLACE OF INTERMENT		14. NAME OF INTERMENT		15. DATE OF INTERMENT		16. SIGNATURE OF MINISTER		17. SIGNATURE OF DECEASED		18. SIGNATURE OF WITNESSES		19. SIGNATURE OF DECEASED		20. SIGNATURE OF WITNESSES		21. SIGNATURE OF DECEASED		22. SIGNATURE OF WITNESSES		23. SIGNATURE OF DECEASED		24. SIGNATURE OF WITNESSES	
CATHOLIC CHURCH		ST. JAMES		12/26/57		J. J. JONES		J. J. JONES		J. J. JONES		J. J. JONES		J. J. JONES		J. J. JONES		J. J. JONES		J. J. JONES		J. J. JONES	

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. CAUSE OF DEATH		9. PLACE OF DEATH		10. TIME OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
JAMES J. JONES		M		45		1912		NEW YORK		LABORER		MARRIED		HEART DISEASE		HOSPITAL		10:00 AM		J. J. JONES		J. J. JONES	
13. PLACE OF INTERMENT		14. NAME OF INTERMENT		15. DATE OF INTERMENT		16. SIGNATURE OF MINISTER		17. SIGNATURE OF DECEASED		18. SIGNATURE OF WITNESSES		19. SIGNATURE OF DECEASED		20. SIGNATURE OF WITNESSES		21. SIGNATURE OF DECEASED		22. SIGNATURE OF WITNESSES		23. SIGNATURE OF DECEASED		24. SIGNATURE OF WITNESSES	
CATHOLIC CHURCH		ST. JAMES		12/26/57		J. J. JONES		J. J. JONES		J. J. JONES		J. J. JONES		J. J. JONES		J. J. JONES		J. J. JONES		J. J. JONES		J. J. JONES	

RECEIVED
BUREAU V.
DEC 26 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13531 Item 2 Film 0214 1-13-58 et
CERTIFICATE OF DEATH

13496

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Washington</u> b. COUNTY <u>D.C.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glenn Dale</u>				c. LENGTH OF STAY IN 1b <u>since 1/6/56</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u> <u>47X-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Glenn Dale Hospital</u>				d. STREET ADDRESS (No other address known) <u>c/o Little Sisters of the Poor</u> IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mary McLoughlin</u>				4. DATE OF DEATH Month Day Year <u>12 22 19 57</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/19/1864</u>	
9. AGE (In years lay birthday) yrs. <u>93</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>nursemaid</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home For Aged</u>		11. BIRTHPLACE (State or foreign country) <u>Ireland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Michael McLoughlin</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Gallagher</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>-----</u>		17. INFORMANT <u>self</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Submaxillary Gland</u> <u>142.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary Tuberculosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>8mo.</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>1/6/56</u> , 19 <u> </u> , to <u>12/22/57</u> , 19 <u> </u> , that I last saw the deceased alive on <u>12/22/57</u> , 19 <u> </u> , and that death occurred at <u>7:30A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Moe Wiess</u> M.D. <u>Glenn Dale Hospital Glenn Dale, Md. 12/22/57</u> PHYSICIAN'S NAME (Type) <u>Moe Wiess</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/24/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Washington DC</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. H. Hamilton</u> ADDRESS <u>3831 So Ave NW</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 26 '57</u>		24b. REGISTRAR'S SIGNATURE <u>Deed</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
MARRIAGE		MARRIED		SINGLE		WIDOW		DIVORCED		SEPARATED		OTHER		REMARKS	
OCCUPATION		PROFESSION		VOCATION		INDUSTRY		ART		SCIENCE		LITERATURE		REMARKS	
EDUCATION		SCHOOL		COLLEGE		UNIVERSITY		GRADUATE		POSTGRADUATE		REMARKS		REMARKS	
RELIGION		METHOD		DOCTRINE		TEACHING		PRACTICE		REMARKS		REMARKS		REMARKS	
CAUSE OF DEATH		DISEASE		SYMPTOMS		SIGNS		TREATMENT		REMARKS		REMARKS		REMARKS	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		REMARKS		REMARKS	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF CLERGYMAN		SIGNATURE OF JUDGE		SIGNATURE OF NOTARY		SIGNATURE OF REGISTRAR		SIGNATURE OF CLERK	
DATE OF SIGNATURE		TIME OF SIGNATURE		PLACE OF SIGNATURE		CITY OF SIGNATURE		STATE OF SIGNATURE		COUNTRY OF SIGNATURE		REMARKS		REMARKS	
REMARKS		REMARKS		REMARKS		REMARKS		REMARKS		REMARKS		REMARKS		REMARKS	

RECEIVED
DEC 26 1957
BUREAU V. H.

13532 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE'S</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bowie</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BOWIE XI</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1</u>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Frieda L.</u> Middle <u>Merkel</u> Last <u>MERKEL</u>				4. DATE OF DEATH Month <u>December</u> Day <u>7</u> Year <u>1957</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 11, 1878</u>	9. AGE (In years last birthday) <u>79</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>German Schuman</u>				14. MOTHER'S MAIDEN NAME <u>Laurie Hopsmyer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Howard Bartholomew Bannick</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pyelonephritis</u> <u>450.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Amputation in Both legs</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 wks.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>11/22</u> , 19 <u>57</u> to <u>11/7</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>11/5</u> , 19 <u>57</u> , and that death occurred at <u>5 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>B P Warren</u> M.D.				305 PRINCE GEORGE ST. 12/7/57			
PHYSICIAN'S NAME (Type) <u>B. P. WARREN</u>				LAUREL MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/9/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Trinity Lutheran Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Bowie Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>De Witt Canadon</u> ADDRESS <u>Laurel Md</u>				24a. REC'D BY REGISTRAR <u>De Witt Canadon</u>		24b. REGISTRAR'S SIGNATURE <u>De Witt Canadon</u>	

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 12 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Fairmont Hghts	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS 701 60th Place	
3. NAME OF DECEASED (Type or print) George Middleton		4. DATE OF DEATH Dec. 18 19 57	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 25 Apr. 1880
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Uremia DUE TO (b) Congestive Heart Failure DUE TO (c) Arteriosclerotic Heart Disease. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-6-1957, to 12-18-1957, that I last saw the deceased alive on 19, and that death occurred at 3:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 12/18 3002 Arundel Road			
ACTUAL SIGNATURE Henry R. Wolfe		M.D. 3002 Arundel Road	
PHYSICIAN'S NAME (Type) Henry R. Wolfe, M. D.		Mt. Rainier, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 12-21-57	22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	22d. LOCATION (City, town, or county) (State) Washington D.C.
23. FUNERAL DIRECTOR'S SIGNATURE Henry S. Washington & Sons 467 N St. N.W.		24a. REC'D BY REGISTRAR DATE DEC 23 57 24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MIDLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

DEC 23 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

13499 24v
Reg. Dist. No.

13533

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seat Pleasant		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 601-63 rd St.		d. STREET ADDRESS 1601-63 rd St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First SALLY Middle PINDELL Last Milburn		4. DATE OF DEATH Month 12 - Day 30 - Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-24-86
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph E. Dove		14. MOTHER'S MAIDEN NAME Molly A. Powell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 579-24-3818A	
17. INFORMANT Sadie Godfrey 601-63 rd St. Seat Pleasant		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Hypertensive-Cardio-Vascular Disease (c)		INTERVAL BETWEEN ONSET AND DEATH 3 days 4 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-11, 1954, to 12-30, 1957, that I last saw the deceased alive on 12-28, 1957, and that death occurred at 7:30 P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Max M. Herzberg		ADDRESS (Street, city or town, state) 7016 - Prep St., Seat Pleasant, Md.	
DATE SIGNED			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-3-57	
22c. NAME OF CEMETERY OR CREMATORY Christ Church Cem.		22d. LOCATION (City, town, or county) (State) Owensville Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co. 517-11 th St. S.E.		24a. REC'D BY REGISTRAR DATE JAN 6 1958	
24b. REGISTRAR'S SIGNATURE Carrie Campbell			

MASSACHUSETTS STATE DEPARTMENT OF HEALTH—BOSTON, 19

BUREAU V. S.

JAN 6 1953

RECEIVED

13534 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Pr. Geo's Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clinton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clinton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS R.F.D. # 1 - Box 650	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MIDDLE Last BESSIE M. MILLER		4. DATE OF DEATH Month Day Year December 31st 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 3rd. 1900
9. AGE (In years last birthday) yrs. 57		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John E. Robey		14. MOTHER'S MAIDEN NAME Olivia Gardner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT John A. Miller		Address SAME as #2 d.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Stomach</u> 151X DUE TO <u>with metastases</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 1 yr.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. _____ 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 12, 1957</u> to <u>Dec 31, 1957</u> that I last saw the deceased alive on <u>Dec 31, 1957</u> , and that death occurred at <u>7:30</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Paul Van Natta</u> M.D. <u>5440 Silver Hill Rd SE DC</u> PHYSICIAN'S NAME (Type) <u>PAUL VAN NATTA</u> <u>Washington D.C.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 2- 58	
22c. NAME OF CEMETERY OR CREMATORY St. John's Cemetery		22d. LOCATION (City, town, or county) (State) Clinton, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Simmons Brothers</u>		24a. REC'D BY REGISTRAR DATE <u>3</u> 1958	
24b. REGISTRAR'S SIGNATURE <u>Carrie Campbell</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES H. HARRIS		MALE		65		JAN 15 1893		BALTIMORE		MD.		MD.		U.S.A.	
MARRIAGE		MARRIED		DATE		PLACE		CITY		STATE		COUNTRY			
MARRIED		MARRIED		JAN 15 1915		BALTIMORE		MD.		MD.		U.S.A.			
EDUCATION		HIGHER		SCHOOL		CITY		STATE		COUNTRY					
HIGHER		HIGHER		SCHOOL		BALTIMORE		MD.		MD.		U.S.A.			
OCCUPATION		MANAGER		FIRM		CITY		STATE		COUNTRY					
MANAGER		MANAGER		FIRM		BALTIMORE		MD.		MD.		U.S.A.			
RELIGION		METHODIST		CHURCH		CITY		STATE		COUNTRY					
METHODIST		METHODIST		CHURCH		BALTIMORE		MD.		MD.		U.S.A.			
CAUSE OF DEATH		HEART DISEASE		CORONARY		ARTHEROSCLEROSIS		CITY		STATE		COUNTRY			
HEART DISEASE		HEART DISEASE		CORONARY		ARTHEROSCLEROSIS		BALTIMORE		MD.		MD.		U.S.A.	
DATE OF DEATH		JAN 15 1958		TIME		10:30 AM		CITY		STATE		COUNTRY			
JAN 15 1958		JAN 15 1958		TIME		10:30 AM		BALTIMORE		MD.		MD.		U.S.A.	
PLACE OF DEATH		HOME		CITY		STATE		COUNTRY							
HOME		HOME		BALTIMORE		MD.		MD.		U.S.A.					
SIGNATURE OF PHYSICIAN		JAMES H. HARRIS		DATE		JAN 15 1958		CITY		STATE		COUNTRY			
JAMES H. HARRIS		JAMES H. HARRIS		DATE		JAN 15 1958		BALTIMORE		MD.		MD.		U.S.A.	
SIGNATURE OF REGISTRAR		JAMES H. HARRIS		DATE		JAN 15 1958		CITY		STATE		COUNTRY			
JAMES H. HARRIS		JAMES H. HARRIS		DATE		JAN 15 1958		BALTIMORE		MD.		MD.		U.S.A.	

BUREAU V. B.

JAN 3 1958

RECEIVED

CERTIFICATE OF DEATH

13501

13476

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE New Jersey b. COUNTY Atlanta			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 9 days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural--Absecon				d. NAME OF HOSPITAL (If not in hospital, give street address) Prince Georges General Hospital			
d. STREET ADDRESS R.D. # 2				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CHARLES Middle LEO Last MILLER				4. DATE OF DEATH Month December Day 13th , Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 15th, 1881	
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months 7 Days 6 Hours 3 Min.		IF UNDER 24 HRS. Months 7 Days 6 Hours 3 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Textile Worker				10b. KIND OF BUSINESS OR INDUSTRY Textile Mill		11. BIRTHPLACE (State or foreign country) Germany	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Leo Miller				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 164-03-0462			
17. INFORMANT Mrs. Philomena M. Mulligan				Address 4817 Erie St. College Park, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Right pulmonary congestion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Metastatic carcinoma, right lung. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from Nov. 19, 1957 to Dec. 13, 1957 , that I last saw the deceased alive on Dec. 13, 1957 , and that death occurred at 6:45 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4713 Berwyn Road, College Park, Md. DATE SIGNED 12/14/1957							
ACTUAL SIGNATURE Wolcott L. Etienne M.D.				PHYSICIAN'S NAME (Type) Wolcott L. Etienne			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/15/1957		22c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		22d. LOCATION (City, town, or county) (State) Roxborough, Phila. Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.				24a. REC'D BY REGISTRAR DEC 18 '57		24b. REGISTRAR'S SIGNATURE Overhach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED [REDACTED]		SEX [REDACTED]	
AGE [REDACTED]		DATE OF BIRTH [REDACTED]	
PLACE OF BIRTH [REDACTED]		DATE OF DEATH [REDACTED]	
TIME OF DEATH [REDACTED]		PLACE OF DEATH [REDACTED]	
CAUSE OF DEATH [REDACTED]		MANNER OF DEATH [REDACTED]	
SIGNATURE OF PHYSICIAN [REDACTED]		SIGNATURE OF REGISTRAR [REDACTED]	
CITY [REDACTED]		COUNTY [REDACTED]	
STATE [REDACTED]		ZIP CODE [REDACTED]	

BUREAU V. S.

DEC 18 1957

RECEIVED

ORIGINAL CONTAINED

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

13477 CERTIFICATE OF DEATH

Reg. Dist. No. 13807

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Prince George's		MARYLAND		STATE Maryland		COUNTY Prince George's	
CITY (If outside corporate limits, write RURAL and give nearest town) Cheverly		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) 33 Bladensburg			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Prince George's General				STREET ADDRESS (If rural give location) 6307 Osborne Road			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) Sherman (Middle) Moore (Last)				December 7 19 57			
5. SEX Male		6. COLOR OR RACE Colored		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH ?	
9. AGE last birthday 63 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				1 week			
570.5 IMMEDIATE CAUSE (A) Leukemia				9 days			
ANTECEDENT CAUSE(S) DUE TO Generalized Peritonitis				20 days			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO Intestinal Obstruction							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION 11/28/57		19b. MAJOR FINDINGS OF OPERATION Obstruction Peritonitis		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21a. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21i. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Dec. 1, 1957, to Dec. 7, 1957, that I last saw the deceased alive on Dec. 7, 1957, and that death occurred at 9:30 PM, from the causes and on the date stated above.							
SIGNATURE G. W. Camaller Jr. Dr. C. Willard Camaller				ADDRESS (Street, city, town, state) DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 12/13/57		NAME OF CEMETERY OR CREMATORY Arlington National		LOCATION (City, town, or county) (State) Arlington, Va.	
24. REC'D BY REGISTRAR DATE FEB 21 '58		REGISTRAR'S SIGNATURE G. W. Camaller Jr.		25. FUNERAL DIRECTOR'S SIGNATURE W. H. Bacon, 1722 7th St., NW, Washington DC		ADDRESS	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL
The bottom copy may be retained by the hospital
TO FUNERAL DIRECTOR: The law requires that
certificate has been executed by the attending
death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

2/11/58 MB

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 1/ Film G224 1-3-58 et

CERTIFICATE OF DEATH

13535

Reg. Dist. No.

13502/24

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo's. Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forest Heights		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forest Heights	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION At home		d. STREET ADDRESS 118- Iroquois Way	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) CARRIE M. MOYER		4. DATE OF DEATH Dec. 25th. 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 20- 1880
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Unknown		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Robinson		14. MOTHER'S MAIDEN NAME Barbara Black	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) m		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Chester R. Moyer		Address Same As 2 D.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443x Congestive Failure DUE TO Hypertensive Cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 Week 1-2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 2, 1957, to Dec. 24, 1957, that I last saw the deceased alive on December 24, 1957, and that death occurred at 8:55 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE D. Phillips Frohman		ADDRESS (Street, city or town, state) DATE SIGNED 2824 Welch Ave SE 12/25/57	
PHYSICIAN'S NAME (Type) D. Phillips Frohman M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 28- 57	
22c. NAME OF CEMETERY OR CREMATORY Riverview Cemetery		22d. LOCATION (City, town, or county) (State) Huntingdon, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Simmons Brothers		24a. REC'D BY REGISTRAR DATE 27 1957	
24b. REGISTRAR'S SIGNATURE Carrie Campbell			

CERTIFICATE OF DEATH

LAST NAME		FIRST NAME		MIDDLE NAME	
JAMES		HARRIS		JUNIOR	
DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH	
JAN 15 1915		BALTIMORE, MD		BALTIMORE, MD	
SEX		RACE		RELIGION	
MALE		WHITE		METHODIST	
EDUCATION		OCCUPATION		INDUSTRY	
HIGH SCHOOL		LABORER		TEXTILE MILL	
MARRIED		SINGLE		WIDOW	
YES		NO		NO	
DATE OF MARRIAGE		PLACE OF MARRIAGE		CITY OF MARRIAGE	
JUL 10 1935		BALTIMORE, MD		BALTIMORE, MD	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
JAN 15 1967		BALTIMORE, MD		BALTIMORE, MD	
HOURS OF DEATH		CAUSE OF DEATH		MANNER OF DEATH	
10:00 PM		HEART DISEASE		NATURAL	
DATE OF AUTOPSY		PLACE OF AUTOPSY		CITY OF AUTOPSY	
JAN 16 1967		BALTIMORE, MD		BALTIMORE, MD	
DATE OF BURIAL		PLACE OF BURIAL		CITY OF BURIAL	
JAN 17 1967		BALTIMORE, MD		BALTIMORE, MD	
DATE OF CREMATION		PLACE OF CREMATION		CITY OF CREMATION	
JAN 17 1967		BALTIMORE, MD		BALTIMORE, MD	
DATE OF INTERMENT		PLACE OF INTERMENT		CITY OF INTERMENT	
JAN 17 1967		BALTIMORE, MD		BALTIMORE, MD	
DATE OF EXHUMATION		PLACE OF EXHUMATION		CITY OF EXHUMATION	
JAN 17 1967		BALTIMORE, MD		BALTIMORE, MD	
DATE OF REINTERMENT		PLACE OF REINTERMENT		CITY OF REINTERMENT	
JAN 17 1967		BALTIMORE, MD		BALTIMORE, MD	

BUREAU V. E.

DEC 27 1967

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13436 CERTIFICATE OF DEATH

Reg. Dist. No.

1350345

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>West Hyattsville</u>		c. LENGTH OF STAY IN 1b <u>5 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>6631 24th Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Emma Mae Osburn</u>		4. DATE OF DEATH Month Day Year <u>Dec. 5 1957</u>	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 26, 1883</u>
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Wash. DC</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas S. Gosnell</u>		14. MOTHER'S MAIDEN NAME <u>-- Bradburn</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>578-01-9630</u>	
17. INFORMANT <u>Clara Kanode</u>		Address <u>6631 24th Ave. W. Hyattsville</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate case (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>15 min</u> <u>10 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of Cervix</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July</u> , 19 <u>55</u> , to <u>Dec 5</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec 5</u> , 19 <u>57</u> , and that death occurred at <u>1:15 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James H. Watloof</u> M.D.		ADDRESS (Street, city or town, state) <u>7701 Carroll Ave</u> DATE SIGNED <u>12-5-57</u>	
PHYSICIAN'S NAME (Type) <u>Takana Park, 12 md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>12/7/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Congressional Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co. - 2901 14th St., N.W.</u>		24. REC'D BY REGISTRAR <u>DEC 10 1957</u>	24b. REGISTRAR'S SIGNATURE <u>James Hines</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED <i>John Doe</i>		SEX <i>Male</i>		AGE <i>45</i>		DATE OF BIRTH <i>Jan 15 1912</i>	
PLACE OF BIRTH <i>John Doe</i>		OCCUPATION <i>Teacher</i>		MARRIAGE <i>Married</i>		DATE OF MARRIAGE <i>Jan 15 1940</i>	
CAUSE OF DEATH <i>Heart Disease</i>		MANNER OF DEATH <i>Natural</i>		DATE OF DEATH <i>Dec 10 1957</i>		PLACE OF DEATH <i>Home</i>	
SIGNATURE OF PHYSICIAN <i>John Doe</i>		SIGNATURE OF CORONER <i>John Doe</i>		SIGNATURE OF WITNESS <i>John Doe</i>		SIGNATURE OF WITNESS <i>John Doe</i>	
DATE OF SIGNATURE <i>Dec 10 1957</i>		DATE OF SIGNATURE <i>Dec 10 1957</i>		DATE OF SIGNATURE <i>Dec 10 1957</i>		DATE OF SIGNATURE <i>Dec 10 1957</i>	

BUREAU V. S.

DEC 10 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

13504

13478

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 45 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 1106- Hyattsville, 15 d. STREET ADDRESS 4106 Oglethorpe Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Robert Upton Parlett				4. DATE OF DEATH Month Day Year 12 17 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-30-1898	
9. AGE (In years last birthday) 60 59 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Well drilling				10b. KIND OF BUSINESS OR INDUSTRY Self		11. BIRTHPLACE (State or foreign country) Annapolis, Maryland	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME Percival K. Parlett				14. MOTHER'S MAIDEN NAME Eugene Linthicum			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. 578 01 8285		17. INFORMANT Mary E. Parlett Address Hyattsville, Maryland.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia (clinical) Sec. to main stem 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bronchial obstruction by mucopurulent secretions 3 days DUE TO (c) Broncho pneumonia 45 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) old cerebral thrombosis with paraplegia partial							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from June 1956 , to Dec 17 1957 , that I last saw the deceased alive on Dec 17 1957 , and that death occurred at 9:15 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3503 Perry St DATE SIGNED 12/17/57							
ACTUAL SIGNATURE Norman Donat Bomeau M.D.							
PHYSICIAN'S NAME (Type) NORMAN DONAT BOMEAU M.D. MT PAINIER MD							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/19/57		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons ADDRESS Hyattsville Md.				24a. REC'D BY REGISTRAR DEC 23 57		24b. REGISTRAR'S SIGNATURE W. H. Leach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

1957

15 days

15 days

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

BUREAU V. S.

DEC 23 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 11, 13, 14 Film G224 1-7-58 et

13479

CERTIFICATE OF DEATH

13505

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 7 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville d. STREET ADDRESS 5034 55th Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Jack First Middle Last Parsons		4. DATE OF DEATH Month Day Year Dec 29 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 2 1900
9. AGE (In years last birthday) yrs. 57		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. 3 27	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Elec engineer		10b. KIND OF BUSINESS OR INDUSTRY Adrent Elec. Cont.	
11. BIRTHPLACE (State or foreign country) Liverpool, England		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME (First name unknown) Parson		14. MOTHER'S MAIDEN NAME Emile Pitt	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE Coronary Thrombosis 571.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Severe, Acute Gastro-Enteritis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 5 hours 7 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 12/22 to 12/29 , 19 57 , that I last saw the deceased alive on 12/29 , 19 57 , and that death occurred at 10 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE C. C. Hageage		ADDRESS (Street, city or town, state) 3308 Perry St., Mt. Rainier, Md.	
DATE SIGNED 12/29/57			
PHYSICIAN'S NAME (Type) Dr. Chas. Hageage			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 31 Dec 1957	
22c. NAME OF CEMETERY OR CREMATORY Geo. Wash. Mem. Park		22d. LOCATION (City, town, or county) (State) PR Geo. Cty. MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE RINALDI Funeral Home		ADDRESS 816 48th St.	
24a. REC'D. BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE Goodenough	

CERTIFICATE OF DEATH

Form No. 1

1. Name of deceased: [illegible]

2. Sex: [illegible]

3. Age: [illegible]

4. Date of death: [illegible]

5. Place of death: [illegible]

6. Cause of death: [illegible]

7. Signature of physician: [illegible]

8. Signature of registrar: [illegible]

9. Date of filing: [illegible]

10. Registrar's name: [illegible]

11. County: [illegible]

12. [illegible]

13. [illegible]

14. [illegible]

15. [illegible]

16. [illegible]

17. [illegible]

BUREAU V. 1

JAN 2 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

13506

1. PLACE OF DEATH o. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md b. COUNTY Pg	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly, Md		c. LENGTH OF STAY IN 1b 21 Days Edmonston Md X2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Annie Reeves Pearce		4. DATE OF DEATH Month Day Year Dec. 27 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 1st, 1878
9. AGE (In years last birthday) yrs. 79		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (State or foreign country) Caldwell, Texas		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown Edward Reeves		14. MOTHER'S MAIDEN NAME (Unknown) Cromartie, Annie Elizabeth	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Address Edmonston, Md. Herbert T. Pearce 4810--48th Ave.,			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 600.0 Broncho pneumonia. Right Lower Lobe. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute pyelonephritis left c abscess formation DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491x			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Dec. 5th, 19 57, to Dec. 27th, 19 57, that I last saw the deceased alive on Dec. 27th, 19 57, and that death occurred at 12:05P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Dr. Etienne		ADDRESS (Street, city or town, state) 4713 - Berwyn Rd College Park, Md	
PHYSICIAN'S NAME (Type) Dr. Etienne		DATE SIGNED 12/27/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 30/1957	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	22d. LOCATION (City, town, or county) (State) Suitland Rd. Pr. Geo. Co. Md.
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co., Riverdale, Md.		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
		DATE DEC 31 '57	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

RECEIVED
DEC 11 1957

RECEIVED
DEC 11 1957
BUREAU V. S.

DEC 11 1957

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13507

13481

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly	c. LENGTH OF STAY IN 1b D.O.A.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 22 Bolmar Manor	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS 3403 40th Avenue	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Alfred Antoine Pellissier	4. DATE OF DEATH 12-18-1957	5. SEX Male 6. COLOR OR RACE white 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH Jan. 7, 1907 9. AGE (In years last birthday) 50 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant		10b. KIND OF BUSINESS OR INDUSTRY Accounting	11. BIRTHPLACE (State or foreign country) New Jersey
13. FATHER'S NAME Antoine Pellissier		14. MOTHER'S MAIDEN NAME Katherine Wolfe	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Elizabeth Pellissier; same as # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular renal disease DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John T. Maloney		DATE SIGNED December 19, 1957	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL burial	22b. DATE THEREOF 12/23/57	22c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cemetery	22d. LOCATION (City, town, or county) (State) Arlington, Va.
23. FUNERAL DIRECTOR'S SIGNATURE The S.H.Hines Co., 2901 14th St. N.W.		24a. REC'D BY REGISTRAR DEC 24 '57 24b. REGISTRAR'S SIGNATURE Alb. Leach	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

DEC 24 1957

BUREAU V. 8

Elizabeth Pelletier; born as P. S.

Elizabeth Pelletier

New Jersey

Jan. 1, 1901

Pelletier

3601 12th Avenue

Colony Manor

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MISSOURI STATE DEPARTMENT OF HEALTH-BALTIMORE 10

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13482 CERTIFICATE OF DEATH

Reg. Dist. No.

13508

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY PG			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b 16 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) xo Carmody Hills		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's Hospital				d. STREET ADDRESS 206 Carmody Hills Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LYDIA Middle PINKARD Last PINKARD			4. DATE OF DEATH Month Dec Day 20 Year 19 57				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 14, 1909		9. AGE (In years last birthday) 48 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Alex., Va.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Robert Nelson Johnson			14. MOTHER'S MAIDEN NAME Ida Mae Bolton				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Linda B. Green Address Miami, Fla. 12840 N.W. 13th Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulm. Cong. & Edema 170x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Adeno Carcinoma of the Left Breast DUE TO (c) with deffine Carcinomatosis						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 1957, to _____, 1957, that I last saw the deceased alive on 20 DEC. , 1957, and that death occurred at 8:55 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 905 SHERIDAN ST. HYATTSVILLE, MD. DATE SIGNED 12/21/57							
ACTUAL SIGNATURE Henry R. Wolfe		M.D. 905 SHERIDAN ST. HYATTSVILLE, MD.					
PHYSICIAN'S NAME (Type) HENRY R WOLFE							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-23-57		22c. NAME OF CEMETERY OR CREMATORY Mt Comfort		22d. LOCATION (City, town, or county) (State) Fairfax Co., Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Cunningham Funeral Home Inc. box 65 Alex., Va.				24a. REC'D BY REGISTRAR DEC 26 1957		24b. REGISTRAR'S SIGNATURE W. H. Smith	

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH BALTIMORE, MARYLAND		DATE OF DEATH 12-26-1957	
NAME OF DECEASED JAMES EARL RAY		SEX Male	
AGE 35		RACE White	
PLACE OF BIRTH MOBILE, ALABAMA		OCCUPATION None	
ADDRESS 306 SOUTH LEXINGTON ROAD BALTIMORE, MARYLAND		CAUSE OF DEATH Gunshot wound	
DATE OF DEATH 12-26-1957		TIME OF DEATH 1:00 PM	
PLACE OF DEATH Room 306, Lexington Hotel 306 South Lexington Road Baltimore, Maryland		NAME OF PHYSICIAN Dr. J. Edgar Hoover	
NAME OF HOSPITAL Lexington Hotel		NAME OF NURSE Mary E. Smith	
NAME OF CORONER J. Edgar Hoover		NAME OF JURY None	
NAME OF FUNERAL HOME J. Edgar Hoover		NAME OF BURIAL PLACE None	
NAME OF INTERVIEWER J. Edgar Hoover		NAME OF WITNESS None	
NAME OF SIGNER J. Edgar Hoover		NAME OF SIGNER None	

RECEIVED
 DEC 26 1957
 BUREAU V. A.

13483 CERTIFICATE OF DEATH

13509

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b X 2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General				d. STREET ADDRESS 6002 Reed Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First Sallie Middle Pittman Last Pittman		4. DATE OF DEATH		Month 12 Day 10 Year 1957	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years last birthday) 54 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Speed, North Carolina		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Knight				14. MOTHER'S MAIDEN NAME Sallie Batts			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Catherine Butler Address 6002 Reed Street			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive left intra ventricular hemorrhage 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive arterio sclerotic heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/10 , 19 57 to 12/10 , 19 57 , that I last saw the deceased alive on 12/10 , 19 57 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 12/10/57							
ACTUAL SIGNATURE John Kehoe M.D.				PHYSICIAN'S NAME (Type) John Kehoe Cheverly, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/13/57		22c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial		22d. LOCATION (City, town, or county) (State) Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John F. Stewart ADDRESS 30 H Street, N.E.				24a. REC'D BY REGISTRAR DATE DEC 12 '57		24b. REGISTRAR'S SIGNATURE W. H. Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

REC 12 1957

RECEIVED

13510

CERTIFICATE OF DEATH

13434

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greenbelt d. STREET ADDRESS 9-L-Laurel Hill Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Sonia First Middle Last Porter		4. DATE OF DEATH 12-1-1957 Month Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 22, 1896 9. AGE (In years last birthday) 61 yrs. IF UNDER 1 YEAR Months Days Hours Min. 8
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? U/S.A	
13. FATHER'S NAME Benjamin LaZoris		14. MOTHER'S MAIDEN NAME Unk	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Alex Boskoff, 3415 Cummings Lane, Greenbelt, Md. Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Tamponade DUE TO Acute myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) Arteriosclerotic Heart Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/27/57 , 19 57 , to 12/1/57 , 19 57 , that I last saw the deceased alive on 12/1/57 , 19 57 , and that death occurred at 4:15 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 30 C Ridge Rd. Greenbelt, Md. DATE SIGNED 12-1-57 ACTUAL SIGNATURE William C. Weintraub M.D. PHYSICIAN'S NAME (Type) Dr. Weintraub			
22a. BURIAL, CREMATIONS, REMOVAL (Specify)		22b. DATE THEREOF	
Removal		12/1/57	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Cedar Hill Cemetery		Southland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Gowers ADDRESS 1756 Tenth Ave N.W. Washington		24a. REC'D BY REGISTRAR DEC 3 '57 DATE 24b. REGISTRAR'S SIGNATURE W. Deane	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Page One of Two

<p>1. NAME OF DECEASED JOHN J. BROWN</p>		<p>2. SEX MALE</p>		<p>3. AGE 45</p>	
<p>4. DATE OF DEATH DEC 2 1957</p>		<p>5. TIME OF DEATH 10:00 AM</p>		<p>6. PLACE OF DEATH HOME</p>	
<p>7. CAUSE OF DEATH HEART DISEASE</p>		<p>8. MANNER OF DEATH NATURAL</p>		<p>9. PLACE OF BIRTH BALTIMORE, MD.</p>	
<p>10. DATE OF BIRTH NOV 10 1912</p>		<p>11. TIME OF BIRTH 10:00 AM</p>		<p>12. PLACE OF BIRTH BALTIMORE, MD.</p>	
<p>13. DATE OF DEATH DEC 2 1957</p>		<p>14. TIME OF DEATH 10:00 AM</p>		<p>15. PLACE OF DEATH HOME</p>	
<p>16. CAUSE OF DEATH HEART DISEASE</p>		<p>17. MANNER OF DEATH NATURAL</p>		<p>18. PLACE OF BIRTH BALTIMORE, MD.</p>	
<p>19. DATE OF BIRTH NOV 10 1912</p>		<p>20. TIME OF BIRTH 10:00 AM</p>		<p>21. PLACE OF BIRTH BALTIMORE, MD.</p>	
<p>22. DATE OF DEATH DEC 2 1957</p>		<p>23. TIME OF DEATH 10:00 AM</p>		<p>24. PLACE OF DEATH HOME</p>	
<p>25. CAUSE OF DEATH HEART DISEASE</p>		<p>26. MANNER OF DEATH NATURAL</p>		<p>27. PLACE OF BIRTH BALTIMORE, MD.</p>	
<p>28. DATE OF BIRTH NOV 10 1912</p>		<p>29. TIME OF BIRTH 10:00 AM</p>		<p>30. PLACE OF BIRTH BALTIMORE, MD.</p>	
<p>31. DATE OF DEATH DEC 2 1957</p>		<p>32. TIME OF DEATH 10:00 AM</p>		<p>33. PLACE OF DEATH HOME</p>	
<p>34. CAUSE OF DEATH HEART DISEASE</p>		<p>35. MANNER OF DEATH NATURAL</p>		<p>36. PLACE OF BIRTH BALTIMORE, MD.</p>	
<p>37. DATE OF BIRTH NOV 10 1912</p>		<p>38. TIME OF BIRTH 10:00 AM</p>		<p>39. PLACE OF BIRTH BALTIMORE, MD.</p>	
<p>40. DATE OF DEATH DEC 2 1957</p>		<p>41. TIME OF DEATH 10:00 AM</p>		<p>42. PLACE OF DEATH HOME</p>	
<p>43. CAUSE OF DEATH HEART DISEASE</p>		<p>44. MANNER OF DEATH NATURAL</p>		<p>45. PLACE OF BIRTH BALTIMORE, MD.</p>	
<p>46. DATE OF BIRTH NOV 10 1912</p>		<p>47. TIME OF BIRTH 10:00 AM</p>		<p>48. PLACE OF BIRTH BALTIMORE, MD.</p>	
<p>49. DATE OF DEATH DEC 2 1957</p>		<p>50. TIME OF DEATH 10:00 AM</p>		<p>51. PLACE OF DEATH HOME</p>	
<p>52. CAUSE OF DEATH HEART DISEASE</p>		<p>53. MANNER OF DEATH NATURAL</p>		<p>54. PLACE OF BIRTH BALTIMORE, MD.</p>	
<p>55. DATE OF BIRTH NOV 10 1912</p>		<p>56. TIME OF BIRTH 10:00 AM</p>		<p>57. PLACE OF BIRTH BALTIMORE, MD.</p>	
<p>58. DATE OF DEATH DEC 2 1957</p>		<p>59. TIME OF DEATH 10:00 AM</p>		<p>60. PLACE OF DEATH HOME</p>	
<p>61. CAUSE OF DEATH HEART DISEASE</p>		<p>62. MANNER OF DEATH NATURAL</p>		<p>63. PLACE OF BIRTH BALTIMORE, MD.</p>	
<p>64. DATE OF BIRTH NOV 10 1912</p>		<p>65. TIME OF BIRTH 10:00 AM</p>		<p>66. PLACE OF BIRTH BALTIMORE, MD.</p>	
<p>67. DATE OF DEATH DEC 2 1957</p>		<p>68. TIME OF DEATH 10:00 AM</p>		<p>69. PLACE OF DEATH HOME</p>	
<p>70. CAUSE OF DEATH HEART DISEASE</p>		<p>71. MANNER OF DEATH NATURAL</p>		<p>72. PLACE OF BIRTH BALTIMORE, MD.</p>	
<p>73. DATE OF BIRTH NOV 10 1912</p>		<p>74. TIME OF BIRTH 10:00 AM</p>		<p>75. PLACE OF BIRTH BALTIMORE, MD.</p>	
<p>76. DATE OF DEATH DEC 2 1957</p>		<p>77. TIME OF DEATH 10:00 AM</p>		<p>78. PLACE OF DEATH HOME</p>	
<p>79. CAUSE OF DEATH HEART DISEASE</p>		<p>80. MANNER OF DEATH NATURAL</p>		<p>81. PLACE OF BIRTH BALTIMORE, MD.</p>	
<p>82. DATE OF BIRTH NOV 10 1912</p>		<p>83. TIME OF BIRTH 10:00 AM</p>		<p>84. PLACE OF BIRTH BALTIMORE, MD.</p>	
<p>85. DATE OF DEATH DEC 2 1957</p>		<p>86. TIME OF DEATH 10:00 AM</p>		<p>87. PLACE OF DEATH HOME</p>	
<p>88. CAUSE OF DEATH HEART DISEASE</p>		<p>89. MANNER OF DEATH NATURAL</p>		<p>90. PLACE OF BIRTH BALTIMORE, MD.</p>	
<p>91. DATE OF BIRTH NOV 10 1912</p>		<p>92. TIME OF BIRTH 10:00 AM</p>		<p>93. PLACE OF BIRTH BALTIMORE, MD.</p>	
<p>94. DATE OF DEATH DEC 2 1957</p>		<p>95. TIME OF DEATH 10:00 AM</p>		<p>96. PLACE OF DEATH HOME</p>	
<p>97. CAUSE OF DEATH HEART DISEASE</p>		<p>98. MANNER OF DEATH NATURAL</p>		<p>99. PLACE OF BIRTH BALTIMORE, MD.</p>	
<p>100. DATE OF BIRTH NOV 10 1912</p>		<p>101. TIME OF BIRTH 10:00 AM</p>		<p>102. PLACE OF BIRTH BALTIMORE, MD.</p>	

BUREAU V. B.

DEC 3 1957

RECEIVED

13536

CERTIFICATE OF DEATH

Reg. Dist. No.

13511

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HILLCREST HEIGHTS</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 HILLCREST HEIGHTS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2114 JAMESON STREET</u>				d. STREET ADDRESS <u>2114 JAMESON STREET</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>B.</u> Last <u>Potzler</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>20</u> Year <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEP. 28, 1871</u>	9. AGE (In years last birthday) yrs. <u>86</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>AUSTRIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOHN BIESMEISEL</u>				14. MOTHER'S MAIDEN NAME <u>PENKERT</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>FRANCES GIEBEL</u> Address <u> </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Heart Disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chr. Myocardiosis</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Arteriosclerosis</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>				
20c. TIME OF INJURY Month, Day, Year Hour o. p. <u> </u> p. m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>
21. I certify that I attended the deceased from <u>June</u> , 19 <u>45</u> to <u>Dec. 20</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec. 19</u> , 19 <u>57</u> , and that death occurred at <u>5:15 p. M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u> </u> DATE SIGNED <u>12-20-57</u>							
ACTUAL SIGNATURE <u>Bernard Katzen</u> M.D. <u>3550 M.W.N. Dr. S.E.</u>							
PHYSICIAN'S NAME (Type) <u>BERNARD KATZEN M.D.</u> <u>Wash. 19, D.C.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/23/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ST. MARY'S</u>		22d. LOCATION (City, town, or county) (State) <u>WASHINGTON, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James T. Ryan, Jr.</u>				ADDRESS <u>317 PA. AVE SE</u>		24a. REC'D BY REGISTRAR <u>DEC 23 '57</u>	
				24b. REGISTRAR'S SIGNATURE <u> </u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

3230

BUREAU V. S.

DEC 23 1957

RECEIVED

<p>1. NAME OF DECEASED [Faint text]</p>		<p>2. SEX [Faint text]</p>	
<p>3. AGE [Faint text]</p>		<p>4. DATE OF BIRTH [Faint text]</p>	
<p>5. PLACE OF BIRTH [Faint text]</p>		<p>6. OCCUPATION [Faint text]</p>	
<p>7. MARITAL STATUS [Faint text]</p>		<p>8. CAUSE OF DEATH [Faint text]</p>	
<p>9. MEDICAL HISTORY [Faint text]</p>		<p>10. DATE OF DEATH [Faint text]</p>	
<p>11. SIGNATURE OF PHYSICIAN [Faint text]</p>		<p>12. SIGNATURE OF REGISTRAR [Faint text]</p>	

10. SIGNATURE OF REGISTRAR
11. SIGNATURE OF PHYSICIAN
12. SIGNATURE OF REGISTRAR
13. SIGNATURE OF PHYSICIAN
14. SIGNATURE OF REGISTRAR
15. SIGNATURE OF PHYSICIAN
16. SIGNATURE OF REGISTRAR
17. SIGNATURE OF PHYSICIAN
18. SIGNATURE OF REGISTRAR
19. SIGNATURE OF PHYSICIAN
20. SIGNATURE OF REGISTRAR
21. SIGNATURE OF PHYSICIAN
22. SIGNATURE OF REGISTRAR
23. SIGNATURE OF PHYSICIAN
24. SIGNATURE OF REGISTRAR
25. SIGNATURE OF PHYSICIAN
26. SIGNATURE OF REGISTRAR
27. SIGNATURE OF PHYSICIAN
28. SIGNATURE OF REGISTRAR
29. SIGNATURE OF PHYSICIAN
30. SIGNATURE OF REGISTRAR
31. SIGNATURE OF PHYSICIAN
32. SIGNATURE OF REGISTRAR
33. SIGNATURE OF PHYSICIAN
34. SIGNATURE OF REGISTRAR
35. SIGNATURE OF PHYSICIAN
36. SIGNATURE OF REGISTRAR
37. SIGNATURE OF PHYSICIAN
38. SIGNATURE OF REGISTRAR
39. SIGNATURE OF PHYSICIAN
40. SIGNATURE OF REGISTRAR
41. SIGNATURE OF PHYSICIAN
42. SIGNATURE OF REGISTRAR
43. SIGNATURE OF PHYSICIAN
44. SIGNATURE OF REGISTRAR
45. SIGNATURE OF PHYSICIAN
46. SIGNATURE OF REGISTRAR
47. SIGNATURE OF PHYSICIAN
48. SIGNATURE OF REGISTRAR
49. SIGNATURE OF PHYSICIAN
50. SIGNATURE OF REGISTRAR
51. SIGNATURE OF PHYSICIAN
52. SIGNATURE OF REGISTRAR
53. SIGNATURE OF PHYSICIAN
54. SIGNATURE OF REGISTRAR
55. SIGNATURE OF PHYSICIAN
56. SIGNATURE OF REGISTRAR
57. SIGNATURE OF PHYSICIAN
58. SIGNATURE OF REGISTRAR
59. SIGNATURE OF PHYSICIAN
60. SIGNATURE OF REGISTRAR
61. SIGNATURE OF PHYSICIAN
62. SIGNATURE OF REGISTRAR
63. SIGNATURE OF PHYSICIAN
64. SIGNATURE OF REGISTRAR
65. SIGNATURE OF PHYSICIAN
66. SIGNATURE OF REGISTRAR
67. SIGNATURE OF PHYSICIAN
68. SIGNATURE OF REGISTRAR
69. SIGNATURE OF PHYSICIAN
70. SIGNATURE OF REGISTRAR
71. SIGNATURE OF PHYSICIAN
72. SIGNATURE OF REGISTRAR
73. SIGNATURE OF PHYSICIAN
74. SIGNATURE OF REGISTRAR
75. SIGNATURE OF PHYSICIAN
76. SIGNATURE OF REGISTRAR
77. SIGNATURE OF PHYSICIAN
78. SIGNATURE OF REGISTRAR
79. SIGNATURE OF PHYSICIAN
80. SIGNATURE OF REGISTRAR
81. SIGNATURE OF PHYSICIAN
82. SIGNATURE OF REGISTRAR
83. SIGNATURE OF PHYSICIAN
84. SIGNATURE OF REGISTRAR
85. SIGNATURE OF PHYSICIAN
86. SIGNATURE OF REGISTRAR
87. SIGNATURE OF PHYSICIAN
88. SIGNATURE OF REGISTRAR
89. SIGNATURE OF PHYSICIAN
90. SIGNATURE OF REGISTRAR
91. SIGNATURE OF PHYSICIAN
92. SIGNATURE OF REGISTRAR
93. SIGNATURE OF PHYSICIAN
94. SIGNATURE OF REGISTRAR
95. SIGNATURE OF PHYSICIAN
96. SIGNATURE OF REGISTRAR
97. SIGNATURE OF PHYSICIAN
98. SIGNATURE OF REGISTRAR
99. SIGNATURE OF PHYSICIAN
100. SIGNATURE OF REGISTRAR

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13512

13485

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>		c. LENGTH OF STAY IN 1b <u>20 months</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>907 Park Hill Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Johnessa</u> First <u>Powers</u> Middle <u>Powers</u> Last		4. DATE OF DEATH <u>12</u> Month <u>26</u> Day <u>19</u> Year <u>57</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 27 1882</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Same</u>	
11. BIRTHPLACE (State or foreign country) <u>Limerick Island, Ireland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Hogan</u>		14. MOTHER'S MAIDEN NAME <u>soakraw</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs Margaret Powers Laurel Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocarditis (Heart)</u> 592X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Heart disease 10 yrs</u> DUE TO (c) <u>Arteriosclerosis of the heart 10 yrs</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Enterocolitis</u> INTERVAL BETWEEN ONSET AND DEATH <u>16 months</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/5</u> , 19 <u>57</u> , to <u>12/26</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12/23</u> , 19 <u>57</u> , and that death occurred at <u>7:30</u> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>J. M. Warren</u> M.D.		<u>Laurel</u> <u>12/26/57</u>	
PHYSICIAN'S NAME (Type) <u>J. M. WARREN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>12-30-57</u>	<u>Calvary Cemetery</u>	<u>Queen Anne's Island N.Y.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Dr. W. H. Canalean</u>		24a. REC'D BY REGISTRAR <u>DEC 31 '57</u>	
ADDRESS <u>Laurel Md</u>		24b. REGISTRAR'S SIGNATURE <u>Reel</u>	

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13537 CERTIFICATE OF DEATH

13513

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges' MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) o. STATE Maryland b. COUNTY Prince Georges'	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheltenham		c. LENGTH OF STAY IN 1b 37 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION --		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X/ Cheltenham	
3. NAME OF DECEASED (Type or print) First Middle Last Cora ---- Rawlings		4. DATE OF DEATH Month Day Year December 31, 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 8, 18 81
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	9. AGE (In years last birthday) 76 yrs.
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William Kidwell		14. MOTHER'S MAIDEN NAME Julia Canter	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		17. INFORMANT John T. Rawlings --Cheltenham, Md.	
16. SOCIAL SECURITY NO. --		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X Cerebral Vascular Accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic C.V. Disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 25 hrs 8 yrs		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1947, to 31 Dec 1957, that I last saw the deceased alive on 31 Dec 1957, and that death occurred at 1:15 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE R. B. Sasscer		DATE SIGNED 31 Dec 57	
PHYSICIAN'S NAME (Type) R. B. Sasscer, M.D.		ADDRESS (Street, city or town, state) Upper Marlboro Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/3/58	22c. NAME OF CEMETERY OR CREMATORY St. Thomas Cemetery	22d. LOCATION (City, town, or county) (State) Croom, Maryland.
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. - Upper Marlboro, Md.		24a. REC'D BY REGISTRAR JAN 6 1958	
24b. REGISTRAR'S SIGNATURE A. H. Hedrick			

7
 8

BUREAU V. S.

9 JAN 1951

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13514

13538 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bradbury Hgts.		c. LENGTH OF STAY IN 1b 30 yrs.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Bradbury Heights			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5305--You St., SE		d. STREET ADDRESS 5305--You St., SE	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARY Middle A. Last RILEY		4. DATE OF DEATH Dec. 18th 1957	
S. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH June 30th, 1880	
9. AGE (In years last birthday) 77		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic	
11. BIRTHPLACE (State or foreign country) Charles Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert Cash		14. MOTHER'S MAIDEN NAME Alice Dutton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Bernard J. Riley-5305--You St., SE Bradbury Hgts		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X Congestive heart failure due to DUE TO Endomyocardial disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) Cardiac renal disease (hypertension) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 9 months 9 months 10 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 20, 1957, to Dec 18, 1957, that I last saw the deceased alive on Dec 17, 1957, and that death occurred at 4:30 PM, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE [Signature] M.D. 1746 R ST NW.			
PHYSICIAN'S NAME (Type) Amos Gordon McDonald			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec 20-57	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suitland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Simmons Bros. 1661- Good Hope Rd SE		24a. RECEIVED BY REGISTRAR DATE DEC 20 '57	
24b. REGISTRAR'S SIGNATURE [Signature]			

CERTIFICATE OF DEATH

13333

Reg. No. 100

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH	
5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. COLOR	
9. DATE OF DEATH		10. TIME OF DEATH		11. PLACE OF DEATH		12. CAUSE OF DEATH	
13. MEDICAL HISTORY		14. PRESENT ILLNESS		15. TREATMENT		16. SIGNATURE OF PHYSICIAN	
17. SIGNATURE OF REGISTRAR		18. SIGNATURE OF WITNESS		19. SIGNATURE OF DECEASED		20. SIGNATURE OF NEXT OF KIN	

RECEIVED
 DEC 20 1957
 BUREAU V. F.

13486

Item 7 Film G224 1-13-58 et

CERTIFICATE OF DEATH

13515

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admision) o. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly Md		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Lewisdale Md	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's General Hospital		d. STREET ADDRESS 7001 22th Place	
3. NAME OF DECEASED (Type or print) First Middle Last Mary Rose		4. DATE OF DEATH Month Day Year Dec 11, 19 57	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 1, 1882
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY self	
11. BIRTHPLACE (State or foreign country) Azores		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Antone Rose		14. MOTHER'S MAIDEN NAME Mary Medeiros	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Agnes Moniz		Address Lewisdale, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) C. U. A. rt. hemi plegia 442x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardio renal disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 12-3-57	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-3, 1957, to 12-11, 1957, that I last saw the deceased alive on 12-11, 1957, and that death occurred at 11:30 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED George J Hageage M.D. 3717-38th Ave 12-12-57 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) George J Hageage 3717 38th avenue Cottage City Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec 16, 1957	22c. NAME OF CEMETERY OR CREMATORY St John's Cemetery	22d. LOCATION (City, town, or county) (State) New Bedford Massachusetts
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville Md.	
24a. REC'D BY REGISTRAR DATE DEC 16 '57		24b. REGISTRAR'S SIGNATURE R. L. ...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 16 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13437

CERTIFICATE OF DEATH

Reg. Dist. No.

13516

1. PLACE OF DEATH a. COUNTY Prince George County				b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 20 minutes				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland				b. COUNTY Prince George																							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General								d. STREET ADDRESS 528 Addison Road								e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																							
3. NAME OF DECEASED (Type or print) First Middle Last Herman HANS Rudolph				4. DATE OF DEATH Month Day Year 12 8 1957				5. SEX Male				6. COLOR OR RACE White				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 10-28-1883				9. AGE (In years last birthday) 74 yrs.				IF UNDER 1 YEAR Months Days Hours Min.				IF UNDER 24 HRS.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk								10b. KIND OF BUSINESS OR INDUSTRY Commerce Dept								11. BIRTHPLACE (State or foreign country) Germany								12. CITIZEN OF WHAT COUNTRY? U.S.															
13. FATHER'S NAME unknown								14. MOTHER'S MAIDEN NAME unknown								15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes War I								16. SOCIAL SECURITY NO. yes								17. INFORMANT Wife Rosa M. Rudolph Same							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema 442x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 1 degree temperature Cardiovascular disease DUE TO (c) _____																INTERVAL BETWEEN ONSET AND DEATH																							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)												20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																											
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19												20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)																			
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Henry R. Wolfe M.D. ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) Henry R. Wolfe, M.D. 905 Sheridan St. Hyattsville, Maryland																																							
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF				22c. NAME OF CEMETERY OR CREMATORY								22d. LOCATION (City, town, or county) (State)																							
Burial				12-11-57				Arlington Cemetery								Arlington, Virginia																							
23. FUNERAL DIRECTOR'S SIGNATURE W. M. Chambers Co Washington, D.C.												24. REG. BY REGISTRAR DATE DEC 12 57				25. REGISTRAR'S SIGNATURE W. M. Chambers																							

BUREAU OF THE ARMY

DEC 12 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13488

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

13517

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greenbelt		c. LENGTH OF STAY IN 1b 2 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 56 E. Ridge Rd		d. STREET ADDRESS 56 E. Ridge Road	
3. NAME OF DECEASED (Type or print) Marjorie Elizabeth Russel		4. DATE OF DEATH Month December Day 19 Year 19 57	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 13, 1887
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Alfred E. Bealle		14. MOTHER'S MAIDEN NAME Gibbons	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Francis E. Stone; 6627 Powhatan St., Riverdale		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive cardiovascular disease. 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED December 19, 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/21/1957	
22c. NAME OF CEMETERY OR CREMATORY John Taylor Memorial		22d. LOCATION (City, town, or county) (State) Temperanceville, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE E. J. Saffell		ADDRESS	
24a. REC'D BY REGISTRAR DEC 24 57		24b. REGISTRAR'S SIGNATURE Op. Louch	

RECEIVED

DEC 24 1957

BUREAU V. S.

December 12, 1957

Form with multiple sections and fields, including headers like "FOR STATE HEALTH USE" and "MEDICAL EXAMINER'S CERTIFICATE OF DEATH". The form contains various checkboxes and text areas for medical and legal documentation.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13539

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

13518

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cottage City		c. LENGTH OF STAY IN 1b 3 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3727 Cottage Terrace		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Fred Peter Schaeffer		4. DATE OF DEATH Month Dec. Day 16, Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 23, 1907
9. AGE (in years last birthday) 50 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Benjamin Schaeffer		14. MOTHER'S MAIDEN NAME Cora Estep	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Vida Schaeffer, Same as # 2.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Universal 4th degree burns of body 916.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) Conflagration in home. (c) Conflagrations in home. DUE TO (c) Conflagrations in home.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Overcome by fumes and burned in his own home.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Overcome by fumes and burned in his own home.	
20c. TIME OF INJURY Month, Day, Year 12- 16 19 57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Cottage City, Pr. Geo. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED December 16, 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/18/57	
22c. NAME OF CEMETERY OR CREMATORIUM Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Va.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville Md.	
24a. REC'D BY REGISTRAR DEC 23 '57		24b. REGISTRAR'S SIGNATURE W. L. Smith	

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT

1. Name of Deceased	2. Date of Death	3. Place of Death	4. Age
5. Sex	6. Race	7. Occupation	8. Cause of Death
9. Manner of Death	10. Signature of Examiner	11. Date of Report	12. Signature of Coroner

BUREAU V. 8

DEC 23 1957

RECEIVED

13459 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>	c. LENGTH OF STAY IN 1b <u>55 mins.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>16 Mt. Rainier</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General</u>		d. STREET ADDRESS <u>14236-34th street</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Fred</u> Middle <u>P.</u> Last <u>Schatz</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>4</u> Year <u>19-57</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 1, 1899</u>
9. AGE (In years last birthday) yrs. <u>58</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>1 Kitchen Equip Eng.</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Frederick Johann Schatz</u>		14. MOTHER'S MAIDEN NAME <u>Augusta Louise Thiele</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>577-40-7546</u>	
17. INFORMANT <u>577-40-7546</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho-Pneumonia</u> <u>193X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Compression of Mid-Brain</u> DUE TO (c) <u>Meningio-Sarcoma of Brain</u>			INTERVAL BETWEEN ONSET AND DEATH <u>24 Hrs.</u> <u>24 Hrs.</u> <u>4 Years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Nov. 8th, 1957</u> , to <u>Dec. 4, 1957</u> , that I last saw the deceased alive on <u>Dec. 4, 1957</u> , and that death occurred at <u>11 p.m.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C. C. Hagedage</u>		M.D. <u>3308 Perry St. Mt. Rainier, Md.</u>	
PHYSICIAN'S NAME (Type) <u>C. C. Hagedage M.D.</u>		<u>3308 Perry St. Mt. Rainier, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/7/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>	22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Malley's Funeral Home Inc.</u>		ADDRESS <u>Mt. Rainier, Md.</u>	24a. REC'D BY REGISTRAR DATE <u>DEC 9 '57</u>
		24b. REGISTRAR'S SIGNATURE <u>DeL...</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

13490

CERTIFICATE OF DEATH

Reg. Dist. No. 13520

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>WASHINGTON</u> b. COUNTY <u>D. C. COLUMBIA</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAUREE</u>		c. LENGTH OF STAY IN 1b <u>adm. 1-28-56</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON D. C. 47X-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>LAUREE SANITARIUM</u>				d. STREET ADDRESS <u>4411 36th Street N.W.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>THERESA</u> Middle <u>SETHIMETSCHER</u> Last <u>SETHIMETSCHER</u>				4. DATE OF DEATH Month <u>DECEMBER</u> Day <u>19</u> Year <u>1957</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 27-1876</u>		9. AGE (In years last birthday) <u>81</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>VIENNA - AUSTRIA</u>		12. CITIZEN OF WHAT COUNTRY? <u> </u>	
13. FATHER'S NAME <u>HERMAN GUTSRUND</u>				14. MOTHER'S MAIDEN NAME <u>MARIE MITTLER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>HOSPITAL RECORDS, LAUREE SANITARIUM</u> Address <u> </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL VASCULAR ACCIDENT</u> DUE TO (b) <u>CEREBRAL ARTERIOSCLEROSIS WITH</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>260X</u> (c) <u>PSYCHOTIC REACTION</u> INTERVAL BETWEEN ONSET AND DEATH <u>SEVERAL DAYS</u> <u>2 SEVERAL YEARS</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1. DIABETES MELLITUS 2. Nonunion of left Fractured hip</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>					
20c. TIME OF INJURY Hour <u> </u> a. <u> </u> p. <u> </u> Month <u> </u> Day <u> </u> Year <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I attended the deceased from <u>Nov. 7</u> , 19 <u>56</u> to <u>Dec. 19</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec. 19</u> , 19 <u>57</u> , and that death occurred at <u>5:45</u> P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Erika P. Kramer</u>		M.D. <u>LAUREE SANITARIUM 12-19-57</u>		ADDRESS (Street, city or town, state) <u>LAUREE MARYLAND</u>		DATE SIGNED <u> </u>	
PHYSICIAN'S NAME (Type) <u>ERIKA P. KRAMER</u>		<u>LAUREE MARYLAND</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>12/20-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George Co</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Goldberg Funeral Home Washington D.C.</u>				ADDRESS <u> </u>		24a. REC'D BY REGISTRAR DATE <u>DEC 23 '57</u>	
				24b. REGISTRAR'S SIGNATURE <u> </u>			

CERTIFICATE OF DEATH

Form 100-100

BUREAU V. S.

DEC 23 1957

RECEIVED

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13491 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13521

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b X/ Glen Dale		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital			d. STREET ADDRESS P.O.Box # 131		
3. NAME OF DECEASED (Type or print) Bert Lawrence Shaffner			4. DATE OF DEATH Dec. 19, 19 57		
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 12, 1889	9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist (Retired)			10b. KIND OF BUSINESS OR INDUSTRY Bu. of Engraving		
11. BIRTHPLACE (State or foreign country) Penna.			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Bert Shaffner			14. MOTHER'S MAIDEN NAME Lyda Fletcher		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. Unknown		
17. INFORMANT Bert F. Shaffner			Address Landover Hills, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock 816X DUE TO Conditions, if any, which gave rise to immediate cause (b) Chrushed chest and fractured skull (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Operator of an automobile in collision with a truck		
20c. TIME OF INJURY Month, Day, Year 9.30 AM 12- 19 19 57			20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work Highway		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Berwyn Hts. Pr. Geo. Md.			20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John T. Maloney			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) John T. Maloney, M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED December 19, 1957		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/23/1957		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery	
22d. LOCATION (City, town, or county) (State) Colmar Manor, Pr. Geo. Co. Md.		23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.			
24a. REC'D BY REGISTRAR DEC 23 '57		24b. REGISTRAR'S SIGNATURE W. W. Chambers			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
DEPT.

BUREAU V. S.

DEC 28 1937

RECEIVED

Name of Deceased		Sex		Age	
Race		Marital Status		Occupation	
Usual Residence		Place of Birth		Date of Birth	
Cause of Death		Manner of Death		Date of Death	
Place of Death		Signature of Examiner		Signature of Coroner	
Date of Report		Time of Report		Initials of Reporter	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13540 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13522

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pr. Geo. b. COUNTY Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beltsville		c. LENGTH OF STAY IN 1b 3 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beltsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 11607 34th Place			d. STREET ADDRESS 11607 34th Place		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Marie Rose Shimberg			4. DATE OF DEATH Month December Day 13 Year 19 57		
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 28, 1907		9. AGE (In years last birthday) 50 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) New York	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME John Cremins		
14. MOTHER'S MAIDEN NAME Genevieve Gammon			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		
16. SOCIAL SECURITY NO. WW 11			17. INFORMANT H. Lee Shimberg; same address as # 2.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Strangulation DUE TO (b) Hanging Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hanging					INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Hanging		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. Dec. 13 19 57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	
20f. (City or town) Beltsville, Pr. Geo. Md.		20g. (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input checked="" type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>John T. Maloney</i> EXAMINER'S NAME (Type) John T. Maloney, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> December 13, 1957		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec 17, 1957		22c. NAME OF CEMETERY OR INTERMENT Arlington National	
22d. LOCATION (City, town, or county) Arlington Virginia		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons			ADDRESS Hyattsville, Md.		
24a. REC'D BY REGISTRAR DATE DEC 18 '57		24b. REGISTRAR'S SIGNATURE <i>Reed</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

13422

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park, Md.				c. LENGTH OF STAY IN 1b 25 years			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 14 College Park, Md.				d. STREET ADDRESS 9150 Baltimore avenue			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9150 Baltimore avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Caroline G. Shoemaker				4. DATE OF DEATH Month Day Year Dec 8, 1957			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 31, 1872	9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Ephriam G. Eckenrode				14. MOTHER'S MAIDEN NAME Elizabeth C. Elder			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		17. INFORMANT Address Ernest Eckenrode College Park, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE PULMONARY EDEM 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE 3 MONTH DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from SEPT 21, 1957 , to DEC 8, 1957 , that I last saw the deceased alive on DEC 8, 1957 , and that death occurred at 11:30 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Thomas F. Collins M.D. 322-H or NE PHYSICIAN'S NAME (Type) THOMAS F. COLLINS MD							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec 11, 1957		22c. NAME OF CEMETERY OR CREMATORY Mt Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Washington D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Gasch's Sons				ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR DATE DEC 12 '57	
				24b. REGISTRAR'S SIGNATURE Quelch			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 12 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13541

CERTIFICATE OF DEATH

13524

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Pr. Geo. Co.</u> <u>8032 New Ft. Wash. Rd. MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Prince Geo. Cty.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>At home</u>		d. STREET ADDRESS <u>8032 New Fort Washington Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>Silbaugh</u> Last <u>Silbaugh</u>		4. DATE OF DEATH Month <u>12/6/57</u> Day <u>19</u> Year <u>19</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/11/1874</u>
9. AGE (In years lost birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>W- Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Silbaugh</u>		14. MOTHER'S MAIDEN NAME <u>Matilda Shaffer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Mrs. Bertha Snyder</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1</u> DUE TO <u>congestive failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>myocardial damage</u> DUE TO <u>arteriosclerotic cardiac disease</u> (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>unknown</u> <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 15, 1956</u> to <u>Dec 6, 1957</u> , that I last saw the deceased alive on <u>Dec 1, 1957</u> , and that death occurred at <u>8:15 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Henry G. Hadley</u>		ADDRESS (Street, city or town, state) <u>1252-6th St. S.W.</u>	
PHYSICIAN'S NAME (Type) <u>Henry G. Hadley, M.D.</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/8/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>LAYFETTE MEMORIAL PARK</u>		22d. LOCATION (City, town, or county) (State) <u>Union Town, Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Rinaldi Funeral Home</u>		ADDRESS <u>816- H- St. N.E.</u>	
24a. REC'D BY REGISTRAR <u>DEC 9 '57</u>		24b. REGISTRAR'S SIGNATURE <u> </u>	

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13525

13542

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b 1 week		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 571 University Blvd.				d. STREET ADDRESS 1867 Wyoming Ave., N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WALTER Middle ALEXANDER Last SILLIMAN				4. DATE OF DEATH Month December Day 9th Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 14th, 1874		9. AGE (In years lost birthday) 83 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mining Engineer		10b. KIND OF BUSINESS OR INDUSTRY Self-Employed		11. BIRTHPLACE (State or foreign country) Pottsville, Penna.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Silliman				14. MOTHER'S MAIDEN NAME (Unknown) Foster			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) None		17. INFORMANT Address Wash. DC A Dorothea VanDemark 215 Webster St. N.E.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic pyelonephritis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) other Mitotic prostate (Malignancy capsule) DUE TO (c) Chronic Myocarditis with hypertension						INTERVAL BETWEEN ONSET AND DEATH 3 years 1 year 12 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. s. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 5th, 1957 to Dec. 9th, 1957 , that I last saw the deceased alive on Dec. 8th, 1957 , and that death occurred at 3:10 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Stanley Paul Porton		M.D. 300 Hamilton St. N.W.		ADDRESS (Street, city or town, state) Washington, D.C.		DATE SIGNED 12/9/1957	
PHYSICIAN'S NAME (Type) Stanley Paul Porton							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/10/1957		22c. NAME OF CEMETERY OR CREMATORY Mt. Moriah Cemetery		22d. LOCATION (City, town, or county) (State) Philadelphia, Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS W.W. Chambers Co. 1400 Chapin St. N.W. Wash. DC				24a. REC'D BY REGISTRAR DATE DEC 12 '57		24b. REGISTRAR'S SIGNATURE W. W. Chambers	

CERTIFICATE OF DEATH

<p>1. Name of deceased: <u>John Doe</u></p>		<p>2. Sex: <u>Male</u></p>		<p>3. Age: <u>45</u></p>	
<p>4. Date of death: <u>Dec 10 1957</u></p>		<p>5. Time of death: <u>10:00 AM</u></p>		<p>6. Place of death: <u>Home</u></p>	
<p>7. Cause of death: <u>Heart Disease</u></p>		<p>8. Immediate cause: <u>Myocardial Infarction</u></p>		<p>9. Underlying cause: <u>Coronary Artery Disease</u></p>	
<p>10. Manner of death: <u>Natural</u></p>		<p>11. Signature of physician: <u>[Signature]</u></p>		<p>12. Signature of registrar: <u>[Signature]</u></p>	
<p>13. Date of registration: <u>Dec 12 1957</u></p>		<p>14. Registrar's name: <u>[Name]</u></p>		<p>15. Registrar's title: <u>[Title]</u></p>	

BUREAU V. E.

DEC 12 1957

RECEIVED

13492 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 9 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ELIZABETH Middle Macdonald Last SIM				4. DATE OF DEATH Month December Day 14th , Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 15th, 1862	9. AGE (In years last birthday) 95 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At home		11. BIRTHPLACE (State or foreign country) Scotland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Neil Macdonald				14. MOTHER'S MAIDEN NAME Margaret Gordon			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give year or dates of service) None		16. SOCIAL SECURITY NO. None		17. INFORMANT James S. Sim, 3609 Jefferson St., Hyattsville Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of breast 170x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 3 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)		(County)	(State)	
21. I certify that I attended the deceased from Nov. 2nd, 1957 to Dec. 14th, 1957 , that I last saw the deceased alive on Dec. 14th, 1957 , and that death occurred at 2:15 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5201 Baltimore Ave., Hyattsville, Md. DATE SIGNED 12/14/1957							
ACTUAL SIGNATURE Leonard Hays		M.D. 5201 Baltimore Ave., Hyattsville, Md.					
PHYSICIAN'S NAME (Type) Leonard Hays							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 18/1957	22c. NAME OF CEMETERY OR CREMATORY Oakwood Cemetery	22d. LOCATION (City, town, or county) (State) Troy, New York				
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.			24a. REC'D BY REGISTRAR DATE DEC 18 '57		24b. REGISTRAR'S SIGNATURE W. W. Chambers		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
JAMES H. HARRIS		JAN 18 1957	
AGE		SEX	
68 years		Male	
RACE		EDUCATION	
White		High School	
MARRIAGE		OCCUPATION	
Married		Retired	
PLACE OF BIRTH		PLACE OF DEATH	
Baltimore, Md.		Baltimore, Md.	
CAUSE OF DEATH		MANNER OF DEATH	
Heart Disease		Natural	
DISEASE OR INJURY		IMMEDIATE CAUSE	
Coronary Artery Disease		Heart Failure	
PREVIOUS ILLNESS		PREVIOUS INJURY	
Hypertension		None	
TREATMENT		HOSPITAL	
Home		St. Joseph's Hospital	
DATE OF BURIAL		PLACE OF BURIAL	
JAN 20 1957		St. Joseph's Cemetery	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
J. H. Harris		J. H. Harris	
DATE		DATE	
JAN 18 1957		JAN 18 1957	

BUREAU V. S.

DEC 18 1957

RECEIVED

13543

CERTIFICATE OF DEATH

13527

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Tennessee b. COUNTY ?			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Andrews AFB Wash 25, D.C. See Reverse				c. LENGTH OF STAY IN 1b. See Reverse			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Andrews Air Force Base Wash 25, D.C.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Tom Middle R Last Sledge				4. DATE OF DEATH Month December Day 4 Year 19 57			
5. SEX Male		6. COLOR OR RACE Cau		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 27 July 1903	
9. AGE (In years lost birthday) 54 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Service Member		11. BIRTHPLACE (State or foreign country) Sweetwater, Tennessee		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 413-46-8842		17. INFORMANT Patients Medical Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Thrombosis, Coronary artery DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 30 minutes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Angina Pectoris (See Reverse Side)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Not Applicable			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 4 Dec 19 57, to 4 Dec 19 57, that I last saw the deceased alive on 4 Dec 19 57, and that death occurred at 5:20 PM, from the causes and on the date stated above.							
ACTUAL SIGNATURE Reginald P. M. McManus				ADDRESS (Street, city or town, state) 1601st USAF Hospital		DATE SIGNED 4 Dec 57	
PHYSICIAN'S NAME (Type) REGINALD P. MCMAUS				Andrews AFB., Washington 25, D.C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/9/57		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) Sweetwater, Tenn	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co., Wash, D.C.				24a. REC'D BY REGISTRAR DEC 9 '57		24b. REGISTRAR'S SIGNATURE DeLoach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1.c. - Patient was in Transit status from US Soldiers Home, Washington, D. C. to Valley Forge Army Hospital, Pennsylvania, for further treatment and disposition. Arrived this hospital approximately 1315 hours, 4 December 1957.

18. Part II - Pulmonary Tuberculosis, Reinfection Type, Moderately advanced, active.

BUREAU V. 3

DEC 9 1957

RECEIVED

1 **FOR STATE HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13493

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13528

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly Md.		c. LENGTH OF STAY IN 1b 33	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bladensburg, Md.		d. STREET ADDRESS 5015 Quincy St	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mary Doretta Spicer		4. DATE OF DEATH Month Dec , Day 26 , Year 1957	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 10, 1869
9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Charles Parker		14. MOTHER'S MAIDEN NAME Elizabeth Shaw	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Amy D. Vincent		Address Bladensburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracranial hemorrhage 9040 DUE TO Conditions, if any, which gave rise to immediate cause (b) Fractured skull (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fall in home of daughter	
20c. TIME OF INJURY Month, Day, Year 5.30 Hour XX p. m. 12-22-57	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) House	20f. (City or town) (County) (State) Silver Springs, Montgomery, Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Dr John T. Maloney		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/28/57	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md.	
24a. REC'D BY REGISTRAR DEC 30 '57		24b. REGISTRAR'S SIGNATURE Outreach	

M 77

I 0

15

2

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of deceased: _____
2. Sex: _____
3. Age: _____
4. Date of birth: _____
5. Place of birth: _____
6. Usual residence: _____
7. Cause of death: _____
8. Manner of death: _____
9. Signature of medical examiner: _____
10. Date: _____

BUREAU V. H.

DEC 30 1957

RECEIVED

13544

CERTIFICATE OF DEATH

Reg. Dist. No.

135234v

1. PLACE OF DEATH o. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Ohio</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillside, Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>72x3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5105 N. St.</u>				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>D.</u> Last <u>STERRETT</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>29</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 28, 1883</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tool maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>machinist</u>		11. BIRTHPLACE (State or foreign country) <u>Pennia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Sterrett</u>				14. MOTHER'S MAIDEN NAME <u>Anna R. Sechrist</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>301-01-7251</u>		17. INFORMANT Address <u>Mrs Kathryn Pentecost Hillside, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of rectum with</u> <u>154X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <u>generalized metastasis</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sep. 5</u> , 19 <u>57</u> , to <u>Dec 29</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec. 29</u> , 19 <u>57</u> , and that death occurred at <u>2:10 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Peter Duss</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>6124 Central ave Capital Heights Md 12/29/57</u>			
PHYSICIAN'S NAME (Type) <u>PETER DUSS</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-2-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Washington Natl.</u>		22d. LOCATION (City, town, or county) (State) <u>Seatons Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>W. W. Chambers Co. Washington, D. C.</u>				24a. RECEIVED BY REGISTRAR DATE <u>JAN 3 1958</u>		24b. REGISTRAR'S SIGNATURE <u>Carmie Campbell</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

PLACE OF DEATH HOSPITAL		MANNER OF DEATH NATURAL		DATE OF DEATH JAN 3 1959	
CITY OF BALTIMORE		COUNTY OF BALTIMORE		STATE OF MARYLAND	
NAME OF DECEASED JOHN J. ROSS		AGE 65		SEX MALE	
RACE WHITE		RELIGION CATHOLIC		EDUCATION HIGH SCHOOL	
OCCUPATION LABORER		MARITAL STATUS MARRIED		PREVIOUS ILLNESS NONE	
CAUSE OF DEATH HEART DISEASE		IMMEDIATE CAUSE CORONARY THROMBOSIS		UNDERLYING CAUSE HYPERTENSION	
DATE OF DEATH JAN 3 1959		PLACE OF DEATH HOME		MANNER OF DEATH NATURAL	
CITY OF BALTIMORE		COUNTY OF BALTIMORE		STATE OF MARYLAND	
NAME OF DECEASED JOHN J. ROSS		AGE 65		SEX MALE	
RACE WHITE		RELIGION CATHOLIC		EDUCATION HIGH SCHOOL	
OCCUPATION LABORER		MARITAL STATUS MARRIED		PREVIOUS ILLNESS NONE	
CAUSE OF DEATH HEART DISEASE		IMMEDIATE CAUSE CORONARY THROMBOSIS		UNDERLYING CAUSE HYPERTENSION	

BUREAU V. 8

JAN 3 1959

RECEIVED

13437 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3 ✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Carroll Manor Home for the Aged				d. STREET ADDRESS 609 21st Street, N. W.			
3. NAME OF DECEASED (Type or print) First Middle Last CHRISTIAN STOLL				4. DATE OF DEATH Month Day Year December 28, 1957			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 31, 1869		9. AGE (In years last birthday) yrs. 88	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brewer				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Germany	
13. FATHER'S NAME Christian Stoll				14. MOTHER'S MAIDEN NAME Christine Bross			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 577-20-1198A		17. INFORMANT Address Miss Marie Stoll, 609-21st St NW	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho-pneumonia 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Stroke Cerebral thrombosis DUE TO (c) generalized atherosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491X							INTERVAL BETWEEN ONSET AND DEATH 5 days 8 weeks 8 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from April, 1957 to Dec 28, 1957, that I last saw the deceased alive on Dec 27, 1957, and that death occurred at 9:40 AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE Robert E. Maher M.D.				ADDRESS (Street, city or town, state) 1835 Eye St. Wash. D.C.			
DATE SIGNED							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/31/57		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suitland Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Lawler's Sons				ADDRESS 1756 Pa. Ave. N. W. Washington, DC		24a. REC'D BY REGISTRAR DATE DEC 31 1957	
				24b. REGISTRAR'S SIGNATURE James Leary			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 31 1957

RECEIVED

13494

CERTIFICATE OF DEATH

Reg. Dist. No.

13531

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 5 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly Manor			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's General Hosp.				d. STREET ADDRESS 6306 Kilmer Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ABNER Middle SWAIN Last SWAIN		4. DATE OF DEATH Month Dec Day 17 Year 57					
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 14 Sep 1880		9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Hotel Manager		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Benjamin Swain				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Address Evelyn Saine Cheverly, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction. ant. left vent. 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cor. Arterio sclerosis 14th. Dec. 1957. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. Month, Day, Year p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on 12/16 , 19 57 , and that death occurred at 6:00 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Henry R. Wolfe		M.D. Chillum Md.		ADDRESS (Street, city or town, state) Chillum, Md.		DATE SIGNED 12/17/57	
PHYSICIAN'S NAME (Type) Henry R. Wolfe							
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		22b. DATE THEREOF Dec 19, 1957		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Md.		24. RECORDED BY REGISTRAR W. H. Reduch	
				DATE DEC 23 1957		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13532

13545

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY PRINCE GEORGE'S CO. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland, Maryland				c. LENGTH OF STAY IN 1b 4 Months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suitland Nursing Home				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> WASHINGTON, D.C. 47X-3			
d. STREET ADDRESS 2256- High Street S.E.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last LOLA M. THOMAS				4. DATE OF DEATH Month Day Year Dce. 13th 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 12th 1881	
9. AGE (In years last birthday) yrs. 76		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) Washington, D.C.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Franklin Perkins				14. MOTHER'S MAIDEN NAME Sarah J. Robey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Address Adelaide Trueman 1256- Pleasant St. S.E. Wash. DC.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Combined hypertensive - arterio - 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) sclerotic heart disease DUE TO (c) —						INTERVAL BETWEEN ONSET AND DEATH 5 mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from July 27, 1957 to Dec. 13, 1957 , that I last saw the deceased alive on Dec. 12, 1957 , and that death occurred at 5:55 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE W.C. Lambert M.D.				ADDRESS (Street, city or town, state) DATE SIGNED 1418 Good Hope Rd S.E. Dec 12/13/57			
PHYSICIAN'S NAME (Type) W. C. LAMBERT M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 16-57		22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Simmone Brothers				ADDRESS 1661- Good Hope Road S.E. Washington, DC.		24a. REC'D BY REGISTRAR DEC 16 1957	
				24b. REGISTRAR'S SIGNATURE Carrie Campbell			

DEC 16 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13495 CERTIFICATE OF DEATH

Reg. Dist. No.

13533
M/V

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CAPITOL HIGHTS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CAPITOL HIGHTS 36</u>	
c. LENGTH OF STAY IN 1b <u>20 YEARS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6211 SHADY SIDE AVE</u>		d. STREET ADDRESS <u>6211 SHADY SIDE AVE</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Ruth Elisabeth Thomas</u>		4. DATE OF DEATH <u>12 29 1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 12 1894</u>
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>WASHINGTON D.C.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>NORMAN NALLS</u>		14. MOTHER'S MAIDEN NAME <u>Bessie V Reed</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>ERNEST J. THOMAS</u>		Address <u>6211 SHADY SIDE AVE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of uterus with</u> <u>174X</u> DUE TO <u>generalized metastasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO <u></u> (c) <u></u> DUE TO <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Oct. 1</u> , 19 <u>57</u> , to <u>Dec. 29</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec 29</u> , 19 <u>57</u> , and that death occurred at <u>7:05</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Peter Duus</u>		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>Peter DUUS</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>12-31-59</u>	22b. DATE THEREOF <u>PROSPECT HILL</u>	22c. NAME OF CEMETERY OR CREMATORY <u>WASHINGTON D.C.</u>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. William Reis</u>	ADDRESS <u>300-4 ST NE</u>	24a. REC'D BY REGISTRAR <u>DEC 31 1957</u>	24b. REGISTRAR'S SIGNATURE <u>Bernie Campbell</u>

BUREAU V. S.

DEC 31 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the delay by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for a burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13534

Reg. Dist. No.

13496

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 37 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Benedict d. STREET ADDRESS 08X1-2 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First George Middle A. Last 109E				4. DATE OF DEATH Month 12 Day 26 Year 1957			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-19-02	
9. AGE (In years last birthday) 55 yrs.		10. IF UNDER 1 YEAR Months 5 Days 26 Hours 19 Min. 57		11. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY Tenant		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME William Loye				14. MOTHER'S MAIDEN NAME Lane Estep			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 491X		17. INFORMANT Gene Loye, Benedict, Md. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 421.1 Antero-septal infarction DUE TO (b) aortic insufficiency DUE TO (c) Bronchopneumonia, rt. middle & lower lobes PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491X							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Lynn				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Dr. John T. Lynn				DATE SIGNED 12/26/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12-28-57		22c. NAME OF CEMETERY OR CREMATORY ST MARY'S CEM		22d. LOCATION (City, town, or county) (State) BRYANTOWN, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Hunt Funeral Home ADDRESS Waldorf, Md.				24a. REC'D BY REGISTRAR DEC 31 '57		24b. REGISTRAR'S SIGNATURE W. H. H. H.	

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED <i>John + Mary</i>		SEX M	
AGE 45		RACE W	
DATE OF DEATH 12-31-57		TIME OF DEATH 10:00 AM	
PLACE OF DEATH 1234 Main St, Baltimore, Md.		CAUSE OF DEATH Heart failure	
MANNER OF DEATH Natural		SIGNATURE OF EXAMINER <i>[Signature]</i>	
SIGNATURE OF NEXT OF KIN <i>[Signature]</i>		SIGNATURE OF WITNESS <i>[Signature]</i>	

RECEIVED
 DEC 31 1957
 BUREAU V. 2

13423

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park, Md.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 14 College Park, Md.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4614 Drexel Road				d. STREET ADDRESS 4614 Drexel Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Frank Middle Vrana Last Sr.				4. DATE OF DEATH Month December Day 13 , Year 19 57.			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 29, 1888	9. AGE (In years last birthday) 69 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Machinist		11. BIRTHPLACE (State or foreign country) Czecho-slovakia		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Martin V Vrana				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		17. INFORMANT Frank Vrana Jr College Park, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL ACCIDENT 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ADVANCED ARTERIOSCLEROSIS DUE TO (c) ? YEARS INTERVAL BETWEEN ONSET AND DEATH 48 hours							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from 3/14, 1951 , to 12/13, 1957 , that I last saw the deceased alive on 12/11, 1957 , and that death occurred at 11:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4506 College Ave DATE SIGNED 12/13/57							
ACTUAL SIGNATURE C. Louis Mendel M.D.		PHYSICIAN'S NAME (Type) C. LOUIS MENDEL College Park Md					
22a. BURIAL, CREMATION, REMOVAL (Specify) Transportation		22b. DATE THEREOF 12/14/57		22c. NAME OF CEMETERY OR CREMATORY Cleveland		22d. LOCATION (City, town, or county) (State) Ohio	
23. FUNERAL DIRECTOR'S SIGNATURE Francis Gasch's Sons				ADDRESS Hyattsville Md.		24a. REC'D BY REGISTRAR DATE DEC 17 '57	
				24b. REGISTRAR'S SIGNATURE W. H. Beach			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text, possibly "John Doe"]		SEX [Faint text, possibly "Male"]		AGE [Faint text, possibly "45"]	
RACE [Faint text, possibly "White"]		BIRTH DATE [Faint text, possibly "01/01/1910"]		BIRTH PLACE [Faint text, possibly "Maryland"]	
DECEASED AT [Faint text, possibly "Home"]		PLACE OF DEATH [Faint text, possibly "Home"]		DATE OF DEATH [Faint text, possibly "01/01/1957"]	
TIME OF DEATH [Faint text, possibly "10:00 AM"]		CAUSE OF DEATH [Faint text, possibly "Heart Disease"]		MANNER OF DEATH [Faint text, possibly "Natural"]	
SIGNATURE OF PHYSICIAN [Faint signature]		SIGNATURE OF DEATH REGISTRAR [Faint signature]		SIGNATURE OF WITNESS [Faint signature]	
PHYSICIAN'S CERTIFICATE [Faint text]		DEATH REGISTRAR'S CERTIFICATE [Faint text]		WITNESS'S CERTIFICATE [Faint text]	

BUREAU V. 1

REC 17 1957

RECEIVED

13546

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beltsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beltsville			
c. LENGTH OF STAY IN 1b 1 Year				d. STREET ADDRESS 4905 Howard Avenue			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Residence				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) WILLIAM EARL WANNALL SR.			4. DATE OF DEATH Month November Day 11 Year 19 57				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> Never married	8. DATE OF BIRTH Oct. 22, 1892		9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Taxie Cab Driver				10b. KIND OF BUSINESS OR INDUSTRY Diamond Cab Co. Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Tell Wannall				14. MOTHER'S MAIDEN NAME Mary Downey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		(If yes, give war or dates of service) None		16. SOCIAL SECURITY NO. 579-12-5262A		17. INFORMANT Norma M. Wannall Address 416 33 St., S.E., Washington, D.C. Apt. #4	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Congestive Heart Failure DUE TO (b) Hypertensive arterio-sclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) 4 years							INTERVAL BETWEEN ONSET AND DEATH 1 week
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary Emphysema							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from December 4, 1957 , to December 11, 1957 , that I last saw the deceased alive on December 4, 1957 , and that death occurred at 6 A. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Hans Wodak			M.D. 30-C RIDGE RD., GREENBELT MD			DATE SIGNED 12-11-57	
PHYSICIAN'S NAME (Type) HANS WODAK, M.D.			30-C Ridge Rd., Greenbelt, Md. 12/11/57.				
22a. BURIAL OR CREMATION Burial		22b. DATE THEREOF Dec. 14, 1957		22c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. CHAMBERS CO., 5801 Cleveland Ave.				ADDRESS Riverdale, Md.		23a. REC'D BY REGISTRAR DEC 16 57	
				23b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9 5709 00 01 00

2215

00000000

011173513

13521

Office

902 HORTON, J. L. & G.

© 1999

Leecher, II, 77

100-2081.

252

...not a threat, do not harm, no harm

0154

of 1000

II 2009 II 01 111

[[306] 2037-1-97

BUREAU V. S.

DEC 16 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13497 CERTIFICATE OF DEATH

Reg. Dist. No. 13537

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesverly, Md				c. LENGTH OF STAY IN 1b 4 Days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Washington D.C. Silesia				d. STREET ADDRESS 8901XXXXX New Fort Rd, SE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Jacob Middle Webster Last				4. DATE OF DEATH Month Dec. Day 13 Year 19 57			
5. SEX M		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-2-72	
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Harrisburg, Va.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Robert Webster				14. MOTHER'S MAIDEN NAME Rebecca Cline			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT Alice Beverage		Address Same as above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO myocardial Insufficiency Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Renal Insufficiency DUE TO (c) Renal Insufficiency PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Renal Insufficiency 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Washington D.C.				20g. (County) Washington D.C.		20h. (State) D.C.	
21. I certify that I attended the deceased from Dec 9 , 19 57 , to Dec 13 , 19 57 , that I last saw the deceased alive on Dec 13, 1957 , and that death occurred at 6:05 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Washington D.C. DATE SIGNED Dec 13-57 ACTUAL SIGNATURE Louis B. Backrack M.D. PHYSICIAN'S NAME (Type) Louis B. Backrack							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 16, 1957		22c. NAME OF CEMETERY OR CREMATORY Clunien Cemetery		22d. LOCATION (City, town, or county) (State) Marlington, West Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros.				ADDRESS 1661-Good Hope Rd., SE Washington, DC		24a. REC'D BY REGISTRAR DEC 16 57	
24b. REGISTRAR'S SIGNATURE W. Heath							

CERTIFICATE OF DEATH

NAME OF DECEASED [REDACTED]		DATE OF DEATH [REDACTED]	
AGE [REDACTED]		SEX [REDACTED]	
RACE [REDACTED]		EDUCATION [REDACTED]	
MARRIAGE [REDACTED]		OCCUPATION [REDACTED]	
PLACE OF BIRTH [REDACTED]		PLACE OF DEATH [REDACTED]	
DATE OF BIRTH [REDACTED]		DATE OF DEATH [REDACTED]	
TIME OF DEATH [REDACTED]		CAUSE OF DEATH [REDACTED]	
MANNER OF DEATH [REDACTED]		MEDICAL HISTORY [REDACTED]	
HISTORY OF PRESENT ILLNESS [REDACTED]		HISTORY OF PREVIOUS ILLNESSES [REDACTED]	
TREATMENT [REDACTED]		PATHOLOGICAL FINDINGS [REDACTED]	
LABORATORY EXAMINATIONS [REDACTED]		POST-MORTEM EXAMINATION [REDACTED]	
SIGNATURE OF PHYSICIAN [REDACTED]		SIGNATURE OF CORONER [REDACTED]	
DATE [REDACTED]		DATE [REDACTED]	

BUREAU V. 1

DEC 16 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13498

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13538

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XO Bowie	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital			d. STREET ADDRESS Box 281		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Calvin Gerard Williams			4. DATE OF DEATH Month Day Year December 26 19 57		
5. SEX Male	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 24, 1957		9. AGE (In years last birthday) yrs. 4 Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) *****		10b. KIND OF BUSINESS OR INDUSTRY *****		11. BIRTHPLACE (State or foreign country) Washington, D.C.	
13. FATHER'S NAME Francis Wilbert Williams			14. MOTHER'S MAIDEN NAME Gertrude Violet Arnold		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Father; same address as # 2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED December 26, 1957	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) to 2857 Burial		22b. DATE THEREOF Church Cemetery		22c. NAME OF CEMETERY OR CREMATORY Bowie, Maryland	
22d. LOCATION (City, town, or county) (State)		23. FUNERAL DIRECTOR'S SIGNATURE John T. Rhiner + Co. 901-3rd St.		24a. REC'D BY REGISTRAR DATE DEC 30 '57	
24b. REGISTRAR'S SIGNATURE S.W. Washington, D.C.					

FOR STATE
EXAMINATION

MISSISSIPPI STATE DEPARTMENT OF HEALTH - BIRMINGHAM
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Place of death: _____

Sex: _____

Age: _____

Color: _____

Marital status: _____

Occupation: _____

Education: _____

Religion: _____

Usual place of abode: _____

Usual mode of travel: _____

Usual mode of transport: _____

Usual mode of conveyance: _____

Usual mode of locomotion: _____

Usual mode of propulsion: _____

Usual mode of propulsion: _____

Usual mode of propulsion: _____

Usual mode of propulsion: _____

Usual mode of propulsion: _____

Usual mode of propulsion: _____

Usual mode of propulsion: _____

Usual mode of propulsion: _____

BUREAU V. 5

DEC 30 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH Prince George COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE North Carolina COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesley		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ahoskie		✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) 77 Prince Georges County Hospital				d. STREET ADDRESS 701-3		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Mary E. Willoughby				4. DATE OF DEATH Month Day Year Dec. 5, 1957 19			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/23/91	9. AGE (In years last birthday) 66 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Odom			14. MOTHER'S MAIDEN NAME Levenia Prichard				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT 4320 Race St. Mrs. George Diggs Portsmouth, Va.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 464X Pulmonary Infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Thrombophlebotrombosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 5 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coronary Infarction						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from Nov 27, 1957, to Dec 5, 1957, that I last saw the deceased alive on Dec 5, 1957, and that death occurred at 6 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Robert P. Gully M.D. 7409 1/2 Wm. St. Landover Hills, Md.							
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type)					
22a. BURIAL, CREMATION, REMOVAL (Specify) removal	22b. DATE THEREOF 12/6/57	22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) Ahoskie, North Carolina			
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Company		ADDRESS 2901 14th St. Washington 9, D.C.		24a. REC'D BY REGISTRAR DATE DEC 10 '57		24b. REGISTRAR'S SIGNATURE W. Beach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

13500

CERTIFICATE OF DEATH

13540

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY P.G.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesverly				c. LENGTH OF STAY IN 1b 54 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's General				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lakeland			
d. STREET ADDRESS 5004 Navahoe Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First LUTHER Middle WILSON Last WILSON				4. DATE OF DEATH Month Dec Day 13 Year 1957			
5. SEX MALE		6. COLOR OR RACE NEGRO		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/25/187	
9. AGE (In years lost birthday) 69 yrs.		IF UNDER 1 YEAR Months 69 Days 69 Hours 69 Min.		IF UNDER 24 HRS. Months 69 Days 69 Hours 69 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Retired R.R.		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME UNKNOWN				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. NO		17. INFORMANT Hospital Records Address NO	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Congestive Heart Failure DUE TO (b) Pulmonary Edema. Myocardial Fibrosis DUE TO (c) Coronary Arteriosclerosis Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Years. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (CONDITION GIVEN IN PART I) Uremia secondary to Bilateral Hydronephrosis & Hydnephrosis							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20c. TIME OF INJURY Hour 19 a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-20 , 19 57 to 12/13 , 19 57 that I last saw the deceased alive on 12/13 , 19 57 , and that death occurred at 12/13 , 19 57 , from the causes and on the date stated above. ADDRESS (Street, city or town, state) NO DATE SIGNED NO							
ACTUAL SIGNATURE John K. ... M.D.							
PHYSICIAN'S NAME (Type) NO							
22a. BURIAL, CREMATION, REMOVAL (Specify) 12-18-57		22b. DATE THEREOF 12-18-57		22c. NAME OF CEMETERY OR CREMATORY Queen's Chapel Cemetery		22d. LOCATION (City, town, or county) (State) Murphy Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Henry S. Washington & Son ADDRESS 467 N St N.W.				24a. REC'D BY REGISTRAR DEC 19 57		24b. REGISTRAR'S SIGNATURE Dr. Kocher	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DECEASED

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

BUREAU V. S.

DEC 19 1957

RECEIVED

13501

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>PS.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly MD</u>				c. LENGTH OF STAY IN 1b. <u>3 hrs 42 min</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George General</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seat Pleasant</u>			
d. STREET ADDRESS <u>6414 Greig Street</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Girl</u> Last <u>Woods</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>1</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-1-57</u>	
9. AGE (In years last birthday) <u>3 hrs 42 min</u>		IF UNDER 1 YEAR Months <u>3</u> Days <u>42</u>		IF UNDER 24 HRS Hours <u>3</u> Min. <u>42</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <u>MD.</u>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>Francis Woods</u>				14. MOTHER'S MAIDEN NAME <u>Betty Spitznagel</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>mother - as above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> 776x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>12/1/57</u> , 19 <u>57</u> , to <u>12/1/57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12/1/57</u> , 19 <u>57</u> , and that death occurred at <u>4:12 P.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>6124 Central Ave</u> DATE SIGNED <u>12/2/57</u> ACTUAL SIGNATURE <u>William Brainin</u> M.D. PHYSICIAN'S NAME (Type) <u>W M BRAININ</u> <u>Capitol Hlth Ctr</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Dec 4 1957</u>		<u>Arlington Va</u>		<u>Arlington Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R J Murphy</u> ADDRESS <u>Funeral Home Arlington Va</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 4 '57</u>		24b. REGISTRAR'S SIGNATURE <u>Robert Smith</u>	

2017334XW2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

BUREAU V. S.

DEC 4 1957

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13542

13502

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 1 day	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Joseph Franklin Woods		4. DATE OF DEATH December 14 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-19-1913
9. AGE (In years last birthday) 44 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Painting	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Benjamin Franklin Woods		14. MOTHER'S MAIDEN NAME Ellen Rebecca Wilt	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Margaret Woods; same address as # 2.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 490X Uremia and shock DUE TO Conditions, if any, which gave rise to immediate cause (b) Bilateral Cortical Necrosis of Kidneys (a), stating the underlying cause lost. (c) Bilateral Lobar pneumonia		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John T. Maloney M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED December 15, 1957	
22a. BURIAL, CREMATION, or REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12/17/1957	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cem		22d. LOCATION (City, town, or county) (State) Culman Manor Ar. Geo. Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co-517-H E St SE. Wash D.C.		24a. REC'D BY REGISTRAR DEC 18 '57	
24b. REGISTRAR'S SIGNATURE W. W. Chambers			

STATE HEALTH DEPT.

STATE OF NEW YORK
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
John T. Jones		Male		45	
Date of Death		Place of Death		Cause of Death	
Dec 18 1957		New York City		Heart Disease	
Time of Death		Occupation		Manner of Death	
10:00 AM		Teacher		Natural	
Signature of Physician		Signature of Medical Examiner		Signature of Coroner	
[Signature]		[Signature]		[Signature]	

BUREAU V. S.

DEC 19 1957

RECEIVED

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13503 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13543

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b 12 hours		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital			d. STREET ADDRESS 831 13th Street		
3. NAME OF DECEASED (Type or print) First Robert Middle Valentine Last Woodward			4. DATE OF DEATH Month Dec. Day 17, Year 19 57		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 14, 1913		9. AGE (In years last birthday) 44 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Service station attendant			10b. KIND OF BUSINESS OR INDUSTRY Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Robert L. Woodward			14. MOTHER'S MAIDEN NAME Mollie A. Rutherford		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes W.W.2 30 yrs			17. INFORMANT Address Burhie, Hilda Woodward, 1017 Sharon Drive, Glenn		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock 976X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Laceration of brain, fracture of skull DUE TO (c) Gunshot wound of head					INTERVAL BETWEEN ONSET AND DEATH Md.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Self inflicted gunshot wound			
20c. TIME OF INJURY Month, Day, Year 4:30 A.M. 12-17 19 57	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		20f. (City or town) (County) (State) Cheverly Pr. Geo. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John T. Maloney			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) John T. Maloney, M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> December 17, 1957		
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 12/17/57		22c. NAME OF CEMETERY OR CREMATORY Front Royal	
22d. LOCATION (City, town, or county) (State) Front Royal Va					
23. FUNERAL DIRECTOR'S SIGNATURE F. Bascha sons Hyattsville Md			24a. REC'D BY REGISTRAR DATE DEC 23 57		24b. REGISTRAR'S SIGNATURE W. H. Seuch

FOR STATE
DEATH CERT.

WEST VIRGINIA STATE DEPARTMENT OF HEALTH-BALTIMORE 19
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of deceased		Age		Sex	
John A. Williams		30 yrs		Male	
Date of death		Place of death		Cause of death	
Dec 28, 1907		Home		Heart disease	
Time of death		Place of burial		Signature of physician	
12 hours		Catholic Cemetery		J. A. Williams	
Signature of medical examiner		Signature of coroner		Signature of registrar	
J. A. Williams		J. A. Williams		J. A. Williams	

BUREAU V. S.

DEC 28 1907

RECEIVED

Handwritten notes and signatures at the bottom of the page.

13547

CERTIFICATE OF DEATH

13544

Item 14. See: Birth Cert.

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Prince Geo.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Prince Geo.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>AQUASCO.</u>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>XO AQUASCO</u> ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>LARRY</u> Middle <u>DAVID</u> Last <u>YOUNG</u>		4. DATE OF DEATH Month <u>12</u> Day <u>27</u> Year <u>19 57</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-25-57</u>
9. AGE (In years lost birthday) yrs. <u>3</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>3</u> Days <u>27</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>md</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>PAUL COAN</u>		14. MOTHER'S MAIDEN NAME <u>Edith HARLEY (Young)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <u>Doris Young</u> Address <u>AQUASCO, md.</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>overwhelming signs</u> <u>493X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pneumonia and asbestosis</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>h</u> <u>Days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Nov 18</u> , 19 <u>57</u> , to <u>Dec 27</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec 27</u> , 19 <u>57</u> , and that death occurred at <u>7:30 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Richard H. Dobsen</u> M.D.		DATE SIGNED <u>Barry Quinn, Md</u>	
PHYSICIAN'S NAME (Type) <u>Richard H. Dobsen</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>12-29-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St Thomas Cem</u>	22d. LOCATION (City, town, or county) (State) <u>AQUASCO, md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>HUNT FUNERAL HOME</u>		ADDRESS <u>WILCOCKS MD</u>	24a. REC'D BY REGISTRAR <u>JAN 2 1958</u>
24b. REGISTRAR'S SIGNATURE <u>W. Leach</u>			

2077385XV4

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1b, File # 223 12-30-57 et

CERTIFICATE OF DEATH

13545

Reg. Dist. No.

13548

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Pr. Geo.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forest Hgts.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forest Hgts. x 2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>332 ONONDAGA DR.</u>				d. STREET ADDRESS <u>332 ONONDAGA DR.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>William F Zimmerman</u>				4. DATE OF DEATH Month Day Year <u>DEC 16 1957</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>w</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>25 Oct 1892</u>	9. AGE (In years last birthday) <u>65</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pressman</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>William G. Zimmerman</u>				14. MOTHER'S MAIDEN NAME <u>Johana Mary Dodrell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>578-05-7682</u>		17. INFORMANT Address <u>Miriam Zimmerman 332 Onondaga Dr.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Generalized arteriosclerosis</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>11/12</u> , 19 <u>57</u> , to <u>11/16</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>11/16/57</u> , and that death occurred at <u>11:40 p.m.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Eugene J. Slop</u> M.D. <u>20</u> <u>Pr. Geo.</u>				ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>W. J. VORKE M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>1900057</u>		<u>1900057</u>		<u>Cedar Hill Cem</u>		<u>Suitland Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Lie Funeral Home 44 Maryland Ave</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 23 1957</u> 24b. REGISTRAR'S SIGNATURE <u>Carrie Campbell</u>			

CERTIFICATE OF DEATH

BUREAU V. S.

DEC 23 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13504 CERTIFICATE OF DEATH

13546

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Penn b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cairnbrook 75 x -3	
d. NAME OF HOSPITAL (If not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS Myne Ave.	
3. NAME OF DECEASED (Type or print) First Mary Middle Zorman Last		4. DATE OF DEATH Month Dec. Day 22 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/12/1889
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Pa		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 169 074 472	
17. INFORMANT Hospital records		Address Cheverly Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260x Diabetes mellitus			INTERVAL BETWEEN ONSET AND DEATH 16 yrs 5 years
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Dec. 22, 1957 , to Dec. 22, 1957 , that I last saw the deceased alive on December 22, 1957 , and that death occurred at 11:45 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Hans Wodak		ADDRESS (Street, city or town, state) DATE SIGNED 30-C Bridge Rd, Greenbelt, Md. 12-23-57	
PHYSICIAN'S NAME (Type) HANS WODAK		30-C BRIDGE RD, GREENBELT, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE WHEN OF 12/27/57	22c. NAME OF CEMETERY OR CREMATORY Grand View Cemetery	22d. LOCATION (City, town, or county) (State) Johnstown Pa
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville Md.	
24a. REC'D BY REGISTRAR DEC 26 57		24b. REGISTRAR'S SIGNATURE Debrauch	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JEC 27 1957

BUREAU V. 2

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD	
CERTIFICATE OF DEATH	
1. NAME OF DECEASED JAMES H. HARRIS	
2. SEX Male	
3. AGE 68	
4. RACE White	
5. PLACE OF BIRTH Maryland	
6. DATE OF BIRTH 1889	
7. PLACE OF DEATH Baltimore, Maryland	
8. DATE OF DEATH 1957	
9. TIME OF DEATH 10:00 AM	
10. CAUSE OF DEATH Heart Disease	
11. MANNER OF DEATH Natural	
12. SIGNATURE OF PHYSICIAN J. H. Harris	
13. SIGNATURE OF REGISTRAR J. H. Harris	
14. SIGNATURE OF WITNESSES J. H. Harris	
15. SIGNATURE OF DECEASED J. H. Harris	
16. SIGNATURE OF NEXT OF KIN J. H. Harris	
17. SIGNATURE OF BURIAL OFFICIAL J. H. Harris	
18. SIGNATURE OF MINISTER OF THE GOSPEL J. H. Harris	
19. SIGNATURE OF CHURCH CLERK J. H. Harris	
20. SIGNATURE OF FUNERAL HOME J. H. Harris	
21. SIGNATURE OF CEMETERY J. H. Harris	
22. SIGNATURE OF INTERVIEWER J. H. Harris	
23. SIGNATURE OF SUPERVISOR J. H. Harris	
24. SIGNATURE OF ASSISTANT SUPERVISOR J. H. Harris	
25. SIGNATURE OF CLERK J. H. Harris	
26. SIGNATURE OF RECEPTIONIST J. H. Harris	
27. SIGNATURE OF TELEPHONE OPERATOR J. H. Harris	
28. SIGNATURE OF MAIL ROOM J. H. Harris	
29. SIGNATURE OF RECORDS SECTION J. H. Harris	
30. SIGNATURE OF GENERAL INVESTIGATIVE DIVISION J. H. Harris	
31. SIGNATURE OF IDENTIFICATION DIVISION J. H. Harris	
32. SIGNATURE OF LABORATORY J. H. Harris	
33. SIGNATURE OF RADIOLOGY J. H. Harris	
34. SIGNATURE OF PATHOLOGY J. H. Harris	
35. SIGNATURE OF ANATOMY J. H. Harris	
36. SIGNATURE OF PHYSIOLOGY J. H. Harris	
37. SIGNATURE OF PSYCHOLOGY J. H. Harris	
38. SIGNATURE OF SOCIOLOGY J. H. Harris	
39. SIGNATURE OF POLITICAL SCIENCE J. H. Harris	
40. SIGNATURE OF ECONOMICS J. H. Harris	
41. SIGNATURE OF HISTORY J. H. Harris	
42. SIGNATURE OF GEOGRAPHY J. H. Harris	
43. SIGNATURE OF ASTRONOMY J. H. Harris	
44. SIGNATURE OF METEOROLOGY J. H. Harris	
45. SIGNATURE OF CLIMATE J. H. Harris	
46. SIGNATURE OF SOIL J. H. Harris	
47. SIGNATURE OF PLANT J. H. Harris	
48. SIGNATURE OF ANIMAL J. H. Harris	
49. SIGNATURE OF MICROBIOLOGY J. H. Harris	
50. SIGNATURE OF BOTANY J. H. Harris	
51. SIGNATURE OF ZOOLOGY J. H. Harris	
52. SIGNATURE OF ENTOMOLOGY J. H. Harris	
53. SIGNATURE OF ORNITHOLOGY J. H. Harris	
54. SIGNATURE OF MALACOLOGICAL J. H. Harris	
55. SIGNATURE OF CONCHOLOGY J. H. Harris	
56. SIGNATURE OF MOLLUSCOLOGY J. H. Harris	
57. SIGNATURE OF CRUSTACEOLOGY J. H. Harris	
58. SIGNATURE OF ARACHNOLOGY J. H. Harris	
59. SIGNATURE OF INSECTOLOGY J. H. Harris	
60. SIGNATURE OF VERTEBRATOLOGY J. H. Harris	
61. SIGNATURE OF MAMMALS J. H. Harris	
62. SIGNATURE OF BIRDS J. H. Harris	
63. SIGNATURE OF REPTILES J. H. Harris	
64. SIGNATURE OF AMPHIBIANS J. H. Harris	
65. SIGNATURE OF FISH J. H. Harris	
66. SIGNATURE OF MARINE MAMMALS J. H. Harris	
67. SIGNATURE OF MARINE BIRDS J. H. Harris	
68. SIGNATURE OF MARINE REPTILES J. H. Harris	
69. SIGNATURE OF MARINE AMPHIBIANS J. H. Harris	
70. SIGNATURE OF MARINE FISH J. H. Harris	
71. SIGNATURE OF MARINE MAMMALS J. H. Harris	
72. SIGNATURE OF MARINE BIRDS J. H. Harris	
73. SIGNATURE OF MARINE REPTILES J. H. Harris	
74. SIGNATURE OF MARINE AMPHIBIANS J. H. Harris	
75. SIGNATURE OF MARINE FISH J. H. Harris	
76. SIGNATURE OF MARINE MAMMALS J. H. Harris	
77. SIGNATURE OF MARINE BIRDS J. H. Harris	
78. SIGNATURE OF MARINE REPTILES J. H. Harris	
79. SIGNATURE OF MARINE AMPHIBIANS J. H. Harris	
80. SIGNATURE OF MARINE FISH J. H. Harris	
81. SIGNATURE OF MARINE MAMMALS J. H. Harris	
82. SIGNATURE OF MARINE BIRDS J. H. Harris	
83. SIGNATURE OF MARINE REPTILES J. H. Harris	
84. SIGNATURE OF MARINE AMPHIBIANS J. H. Harris	
85. SIGNATURE OF MARINE FISH J. H. Harris	
86. SIGNATURE OF MARINE MAMMALS J. H. Harris	
87. SIGNATURE OF MARINE BIRDS J. H. Harris	
88. SIGNATURE OF MARINE REPTILES J. H. Harris	
89. SIGNATURE OF MARINE AMPHIBIANS J. H. Harris	
90. SIGNATURE OF MARINE FISH J. H. Harris	
91. SIGNATURE OF MARINE MAMMALS J. H. Harris	
92. SIGNATURE OF MARINE BIRDS J. H. Harris	
93. SIGNATURE OF MARINE REPTILES J. H. Harris	
94. SIGNATURE OF MARINE AMPHIBIANS J. H. Harris	
95. SIGNATURE OF MARINE FISH J. H. Harris	
96. SIGNATURE OF MARINE MAMMALS J. H. Harris	
97. SIGNATURE OF MARINE BIRDS J. H. Harris	
98. SIGNATURE OF MARINE REPTILES J. H. Harris	
99. SIGNATURE OF MARINE AMPHIBIANS J. H. Harris	
100. SIGNATURE OF MARINE FISH J. H. Harris	